

## Patient Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Gender: M or F Marital Status: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS #: \_\_\_\_\_

Address: \_\_\_\_\_ City, State & Zip: \_\_\_\_\_

Phone Numbers: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Email Address: \_\_\_\_\_

Best way to confirm appointments?     Home    Email    Cell    Work

Employer: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

Emergency Contact & Phone Number: \_\_\_\_\_

## Dental Insurance Information

**Primary Insurance:** \_\_\_\_\_

Patients Relationship to Insured (please circle):      Self                  Spouse                  Child

Other

Name of Subscriber: \_\_\_\_\_

Subscriber's Birthdate: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Subscriber's Address: \_\_\_\_\_ Subscriber's Employer \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_

Patients Relationship to Insured (please circle):      Self                  Spouse                  Child

Other

Name of Subscriber: \_\_\_\_\_

Subscriber's Birthdate: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Subscriber's Address: \_\_\_\_\_ Subscriber's Employer \_\_\_\_\_

Douglas R. Bowman, DDS, MS

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF  
PRIVACY PRACTICES**

**\*\* You may refuse to sign this acknowledgement \*\***

I, \_\_\_\_\_, have received a copy of this office's  
Notice of Privacy Practices.

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**For Office Use Only:**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices,  
but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

GENTLE CARING DENTISTRY  
CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of \_\_\_\_\_'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written, or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care options. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protections of my personal health information is available.
5. I HAVE READ, UNDERSTAND, AND ACCEPT THE TERMS OF THE ABOVE OUTLINED POLICIES FOR INSURANCE HANDLING AND FINANCIAL COMMITMENTS THAT I MAY INCUR AS A RESULT OF TREATMENT. I KNOW THAT ANYTHING INSURANCE DOES NOT COVER IS MY RESPONSIBILITY. IF NO INSURANCE, I KNOW THAT ALL PAYMENTS ARE DUE AT THE TIME SERVICES ARE RENDERED UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. I KNOW THAT IF I DON'T PAY MY OUTSTANDING BALANCE, AND THE ACCOUNT IS SENT TO COLLECTION OR SMALL CLAIMS COURT, I WILL BE RESPONSIBLE FOR ANY LATE CHARGE (18% PER ANNUM INTEREST RATE), ATTORNEY FEES OR COLLECTION FEES THAT MAY BE INCURRED.

Patients Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Responsible Party's Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

# Welcome to Gentle Caring Dentistry!

## Office Policy

### **AGREEMENT FOR PAYMENT FOR SERVICES:**

Full payment for services is due at the time of service, and collected at the beginning of each appointment. Any insurance co-payments are due at time of service. You must provide your insurance and identification-at-each visit, which is subject for verification prior to your appointment time. Gentle Caring Dentistry reserves the right to cancel your appointment if proof of insurance cannot be verified or is not provided or require full visit fee be paid prior to your appointment.

**Co-Insurance-** A percentage of your visit which is estimated on the amount your insurance discount allows for the type of service you are receiving. This amount will change from visit to visit depending on the services you are scheduled for, or if treatment changes from what was originally scheduled.

**Self-Pay-** When you do not have an insurance discount plan, you will be quoted an amount for your services scheduled. This amount could increase or decrease if treatment changes for any reason. Our staff will make sure you are aware of any additional costs before you agree to any treatment.

### **SCHEDULING AGREEMENT:**

In order for Gentle Caring Dentistry's staff to schedule you in a timely manner and allow for timely follow up appointments, it is your responsibility to communicate when you are unable to keep your appointments not only as a courtesy to your provider and other patients, but also for administrative purposes as our staff prepares for each and every patient visit. Please be advised that 3 no shows can result in discharge from the practice.

**24 hour notice must be provided to cancel an appointment** or a missed appointment fee of \$50.00 will be charged to your account and you may not be able to reschedule the missed appointment until this fee is taken care of.

### **UNDERSTANDING YOUR COSTS:**

While Gentle Caring Dentistry staff strives to make sure all of of your financial obligations for services are clearly explained to you prior to your visit, **it is your responsibility as a patient to understand what your insurance covers and does not.** Gentle Caring Dentistry recommends you contact your insurance company by calling the number listed on your insurance card and inquire about your dental benefits as far as coverage percentages, frequencies, any age limitations, or waiting periods for services. This will help you to be aware of any costs that may become your responsibility due to any limitations or stipulations your insurance plan may have that have been negotiated by your employer.

**We bill insurance as a courtesy.** Dental insurance is a contract between the employer and the patient. It has no connection at all to us as your dental office. The extent of coverage varies greatly from company to company, sometimes, even within a company. It has absolutely nothing to do with the level of service provided by us, and the fee charged for these services.

An often-misunderstood term used by many insurance companies is “UCR”. This means **Usual Customary and Reasonable**. What this means is that the insurance company places a set fee for each dental procedure. If the fee is above their “UCR” then the patient is responsible for anything the insurance does not take care of. Despite our best efforts at giving you an accurate **estimate**, a patient will owe the amount of the difference. Again, this has nothing to do with the fee charged, but with the level of coverage negotiated by your employer and decided upon by the insurance company.

I also understand and acknowledge that I am personally responsible to pay Gentle Caring Dentistry in full for services that my dental insurer will not cover due to non-payment of my dental insurance premiums.

### **OUTSTANDING BALANCES:**

Gentle Caring Dentistry requires all outstanding balances to be paid in full prior to scheduling. We reserve the right to deny services until accounts are paid in full. Not fulfilling financial obligations to our office is also grounds for discharge from the practice. If there is ever a credit balance on your account at anytime and you are still receiving treatment please note that the credit will be applied to future fees incurred. Overpayments on accounts will be refunded if no longer receiving services within a period of six months.

### **OTHER COSTS:**

Any returned check or reoccurring credit card payment with insufficient funds will result in an additional fee of \$35.00 and you will no longer be able to pay with that form of payment.

**STATEMENTS:** Each month you will receive a statement for your portion of any bill that is due within 20 days of receipt. You will be asked at your next appointment for any outstanding balance payment in full unless prior arrangements for payments have already been made. If you ever have any questions about your bill or you have the need to make payment arrangements due to hardship, loss of insurance, job or other, please contact our billing department and we will be happy to assist you in your options for continuing your care.

**COMMUNICATION:** We use a system called Smile Reminder that will send email and text message reminders for any scheduled appointments or when you are past due for services. You can easily reply to the messages. We do ask however that you do not use this service to cancel appointments. All cancellations must be made by contacting the office directly by phone at 419-332-1303 where messages can be left if a staff member is not available to take your call.

**I HAVE READ, UNDERSTAND, AND ACCEPT THE TERMS OF THE ABOVE OUTLINED POLICIES FOR INSURANCE HANDLING AND FINANCIAL COMMITMENTS THAT I MAY INCUR AS A RESULT OF TREATMENT. I KNOW THAT ANYTHING INSURANCE DOES NOT COVER IS MY RESPONSIBILITY. IF NO INSURANCE, I KNOW THAT ALL PAYMENTS ARE DUE AT THE TIME SERVICES ARE RENDERED UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. I KNOW THAT IF I DON'T PAY MY OUTSTANDING BALANCE, AND THE ACCOUNT IS SENT TO COLLECTION OR SMALL CLAIMS COURT, I WILL BE RESPONSIBLE FOR ANY LATE CHARGE (18% PER ANNUM INTEREST RATE), ATTORNEY FEES OR COLLECTION FEES THAT MAY BE INCURRED.**

# Medical & Dental History

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Name & Phone number of Medical Doctor: \_\_\_\_\_

Are you currently under a physician's care?  Yes  No Date of last medical visit: \_\_\_\_\_

Medications currently taking: \_\_\_\_\_

Have you ever had any of the following? Please check those that apply:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Allergies<br>If yes, to what:<br>_____       | <input type="checkbox"/> Aids/Immune disorders                           | <input type="checkbox"/> Prolonged bleeding                           |
| <input type="checkbox"/> Metal reactions                              | <input type="checkbox"/> Tuberculosis                                    | <input type="checkbox"/> Asthma                                       |
| <input type="checkbox"/> Heart disease<br>If yes, what type?<br>_____ | <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Unusual reaction to anesthetic or drug       |
| <input type="checkbox"/> Stents                                       | <input type="checkbox"/> Seizures  | <input type="checkbox"/> Allergy to novacaine                         |
| <input type="checkbox"/> Rheumatic fever                              | <input type="checkbox"/> Epilepsy  | <input type="checkbox"/> Allergy to latex                             |
| <input type="checkbox"/> Heart murmur                                 | <input type="checkbox"/> Anemia  | <input type="checkbox"/> Nervous disorders                            |
| <input type="checkbox"/> Pacemaker                                    | <input type="checkbox"/> Venereal disease                                | <input type="checkbox"/> Mental disorders                             |
| <input type="checkbox"/> Heart valve problems/MVP                     | <input type="checkbox"/> Cancer<br>If yes, what type<br>_____            | <input type="checkbox"/> Currently taking blood thinner               |
| <input type="checkbox"/> High blood pressure                          | <input type="checkbox"/> Joint replacement<br>If yes, what type<br>_____ | <input type="checkbox"/> Currently taking medication for osteoporosis |
| <input type="checkbox"/> Low blood pressure                           | Who performed the surgery?<br>Date?<br>_____                             | <input type="checkbox"/> Alcoholism                                   |
| <input type="checkbox"/> Kidney disease                               |  | <input type="checkbox"/> Use tobacco products                         |
| <input type="checkbox"/> Liver disease                                |  | <input type="checkbox"/> Use recreational drugs, including cocaine    |
| <input type="checkbox"/> Hepatitis                                    |  |   |
| <input type="checkbox"/> Currently Taking Asprin                      |  |   |

Has any doctor prescribed an antibiotic before having any dental treatment?  Yes  No

If yes, for what reason? \_\_\_\_\_

Does anyone in your family have a history of:

- Diabetes     High Blood Pressure     Low Blood Pressure     Heart Disease     Cancer

Female patients: Are you pregnant? ?  Yes  No If yes, when is your due date? \_\_\_\_\_

Is there any other information that would be important to your dental or medical health? \_\_\_\_\_

Previous dentist: \_\_\_\_\_ Date of last visit & reason: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Whom may we thank for referring you to our office: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_ **OVER**

## Patient Questionnaire

Please answer the following questions:

Are you having discomfort at this time?  Yes  No

Does dental treatment make you nervous?  No  Slightly  Moderately  Extremely

Have you ever been treated for periodontal disease (gum disease)?  Yes  No

How often do you brush your teeth? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

What kind of brush do you use?  Soft  Medium  Hard  Electric  Battery powered  Manual

Do you have or have you ever had any of the following? Please check all that apply.

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Bleeding sore gums           | <input type="checkbox"/> Clicking/popping jaw        | <input type="checkbox"/> Sensitive to cold       |
| <input type="checkbox"/> Unpleasant taste/bad breath  | <input type="checkbox"/> Difficulty open/closing jaw | <input type="checkbox"/> Sensitive to sweets     |
| <input type="checkbox"/> Burning tongue/lips          | <input type="checkbox"/> Change/shifting in bite     | <input type="checkbox"/> Sensitive to biting     |
| <input type="checkbox"/> Frequent blister, lips/mouth | <input type="checkbox"/> Do you use fluoride rinse   | <input type="checkbox"/> Food impaction          |
| <input type="checkbox"/> Swelling/lumps in mouth      | <input type="checkbox"/> Gag easily                  | <input type="checkbox"/> Clenching/grinding      |
| <input type="checkbox"/> Ortho treatments (braces)    | <input type="checkbox"/> Loose teeth                 | <input type="checkbox"/> Teeth removed/extracted |
| <input type="checkbox"/> Biting cheeks/lips           | <input type="checkbox"/> Sensitive to hot            |  |

These are the things that are most important to me about my dental treatment:

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What do you fear most about dental care?

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My mouth is:  very comfortable  moderately comfortable  uncomfortable

I think my present state of dental health is:  excellent  good  poor

I:

- think the appearance of my mouth is excellent
- am satisfied with the appearance of my mouth
- am dissatisfied with the appearance of my mouth
  
- will do anything to keep natural teeth
- want to keep my teeth but have a certain budget of time & money that I am willing to spend on them
  
- have set goals for my oral health with a previous dentist
- want to set goals concerning my dental health
  
- have always done the best that was recommended for my dental health
- have not done what the dentists have recommended to me
- rarely go, and don't care much about having any dental work completed
  
- have put dentistry for myself and family high on my priority list
- put dentistry for myself and my family low on my priority list
- dentistry is somewhere on my list but it's hard to find

Please check any items you would like additional information on:

- Teeth replacement options
- Invisalign or braces
- Zoom whitening for whitening options
- Financing/payment options
- Sedation options

# DOUGLAS R. BOWMAN, DDS, MS

## NOTICE OF PRIVACY PRACTICES

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THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

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### OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect June 1, 2002, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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### USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

(continued)



**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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#### **PATIENT RIGHTS**

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before June 1, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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#### **QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices or have questions or concerns, please contact us. If your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

**Contact Officer:** Douglas R. Bowman, DDS, MS      **Phone:** (419) 332-1303

**Address:** 1229 Napoleon Street ~ Fremont, OH 43420