Richard Bowen, DDS
Taryn Gehlert, DDS
General, Cosmetic & Implant Dentistry
www.bowenlegacydental.com
Tel: 614-459-2300
770 Jasonway Ave.
Columbus, OH 43214

PATIENT INFORMATION

Date:_______________

Our passion is to provide you with a totally different experience. Giving you the results you are seeking with better communication and treatment options. **We are creators of new lifestyles through smiles.**

☐Dr. ☐Mr. ☐Mrs. ☐Miss

Name____ I prefer to be called__________________________________

Person Responsible for account______________________________________

Relationship____

Home Address______________________________________ City_________________________ State ______ Zip____________________

Marital Status: ☐Single ☐Married ☐Separated ☐Widow(er)

Home Phone______________________ Work Phone_______________________ Cell_____________________________

Email_____________________________________ Where do you prefer to receive calls?_________________________

Birth date__________________ Soc.Sec#______________________ Drivers Lic.#________________________

What is your occupation?_________________________________ Employer___________________________________

Name of Spouse or Parent if Minor_______________________________________

If Patient is a minor, Mother & Father's names & birthdates:

____

How did you hear about our office? ☐Internet search ☐Online Reviews ☐Print Media ☐Personal Referral ☐Social Media

Personal referral: If so, whom may we thank? ____

EMERGENCY INFORMATION

In case of emergency who should we contact?

Name___________________________________ Phone___________________________ Relation______________________

INSURANCE INFORMATION

Do you have dental insurance? ☐Yes ☐No If yes, which carrier?____

Policy holder name____ DOB________________ SS#______________________

Employer__________________________________ Insurance Company Address____

Phone_________________________ Group#__________________ Policy#_____________________ Payor ID_____________

Do you have secondary insurance?__________________

Initials__________ Date____________

Richard Bowen, DDS
Taryn Gehlert, DDS
General, Cosmetic & Implant Dentistry

www.bowenlegacydental.com
Tel:614-459-2300
770 Jasonway Ave.
Columbus, OH 43214

HEALTH HISTORY

Name of personal physician________________________________ Phone#______________________

Date of last physical_________________

How do you assess your current health? ☐Excellent ☐Good ☐Fair ☐Poor

Are you currently under the care of a physician? ☐Yes ☐No

Please list any specialists you see and their specialty____

Please mark any that apply:

☐Anxiety
☐AIDS/HIV
☐Arthritis, Rheumatism
☐Artificial Heart Valves
☐Artificial Joints
☐Asthma
☐Bleeding abnormally
☐Blood Disease
☐Cancer
☐Chemotherapy
☐Circulatory Problems
☐Cortisone Treatments
☐Cough, persistent
☐Depression
☐Epilepsy
☐Fainting or dizziness
☐Glaucoma
☐Heart Lesions

☐Heart Murmur
☐Heart Problems
☐Hepatitis Type____
☐High Blood Pressure
☐Kidney Disease
☐Liver Disease
☐Mitral Valve Prolapse
☐Nervous Problems
☐Pacemaker
☐Psychiatric Care
☐Radiation Treatment
☐Rheumatic Fever
☐Scarlet Fever
☐Sinus Trouble
☐Sleep Apnea
☐Stroke
☐Swollen Feet or Ankles
☐Swollen Neck Glands

☐Thyroid Problems
☐Tonsillitis
☐Tuberculosis
☐Tumor/Growth in head
☐Ulcer

☐Headaches
☐Jaw Pain
☐Jaw Popping
☐Limited Opening
☐Congested Ears
☐Posture Problems
☐Clenching
☐Grinding
☐Facial Pain
☐Neck Ache
☐Bell's Palsy

Please list any allergies: ____

Have you taken or are you currently taking medications for osteoporosis known as bisphosphonates? (For example Fosamax, Actonel or Boniva) ☐Yes ☐No If yes, medication name_____________________ Dates________________

Do you smoke or use chewing tobacco? ☐Yes ☐No How much?______________ For how long?_______________

In the last 5 years have you seen a ☐Chiropractor ☐Neurologist ☐Massage Therapist ☐ENT

Are you currently taking prescription medications? If yes, please list name dosage and purpose________________________

____

____

____

Richard Bowen, DDS
Taryn Gehlert, DDS

General, Cosmetic & Implant Dentistry

www.bowenlegacydental.com
Tel: 614-459-2300

770 Jasonway Ave.
Columbus, OH 43214

DENTAL HISTORY

If you could wave a wand and change anything you could about the appearance of your smile, what would you want different?
____
____

What was the date of your last dental visit?___________________ Previous Dentist Name_______________________

City, State________________________________ Phone_____________________________

Have you ever had a less than positive dental experience? ☐Yes ☐No

If so, please explain____

Have you seen an Orthodontist, had your bite adjusted, or been treated for TMJ?_______________________

What is the most important thing to you about your future smile and dental health?___________________________
____

What is the most important thing to you about your visit today?____
____

If you would whiten your teeth for a cost anyone could afford, would you do it?_________________________________

Have you professionally whitened before? ☐Yes ☐No

Please check any of the following that applies to you:

☐Sensitivity
☐Tooth pain or discomfort when chewing
☐Headaches, ear aches, neck pain
☐Mouth ulcers or cold sores
☐Broken tooth or fillings
☐Grinding or clenching teeth
☐Bleeding, swollen or irritated gums
☐Loose, tipped or shifting teeth
☐Bad breath or bad taste in your mouth
☐Jaw joint pain
☐Clicking, popping in jaw joint
☐Muscle pain in the jaw, temple region, neck area

On a scale of 1-10, with 10 being the highest rating:

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Importance of my overall health?
1 2 3 4 5 6 7 8 9 10

Importance of preventive care to me?
1 2 3 4 5 6 7 8 9 10

Importance of a cosmetic smile?
1 2 3 4 5 6 7 8 9 10

How often do you brush your teeth?______________________ How often do you floss?____________________

What other dental aids do you use?(Electric toothbrush, Water-Pik, toothpicks, Soft-Picks, etc)_________________
____

Initials__________ Date_____________

Initials__________ Date_____________

Richard Bowen, DDS
Taryn Gehlert, DDS

General, Cosmetic & Implant Dentistry

www.bowenlegacydental.com
Tel: 614-459-2300

770 Jasonway Ave.
Columbus, OH 43214

CONSENT TO DENTAL PHOTOGRAPHY

I, ___________________________________, authorize Bowen Legacy Dental, to take photographs, and/or videos of my face, jaws
(Patient name)
and teeth, before during and after treatment.

I consent to allow the photographs to be used for the follow:

- Dental Records
- Dental Research
- Dental Education including lectures, seminars, demonstrations and professional publications such as journals or books
- Marketing material, including websites and printed materials, patient education and social media posts

I further understand that if the photographs and/or videos are used, my full name and/or other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these photographs.

Patient Signature_______________________________________ Date___________________________

-OR-

☐ I do not want my full-face shot used for any of the above purposes

Patient Signature_____________________________________ Date______________________________

Richard Bowen, DDS
Taryn Gehlert, DDS
General, Cosmetic & Implant Dentistry

www.bowenlegacydental.com
Tel: 614-459-2300
770 Jasonway Ave.
Columbus, OH 43214

FINANCIAL GUIDELINES

We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa and Discover. Outside financing is available upon request and approval.

Please check if you would like more information about financing options. ☐

Please note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges incurred.

Do you have insurance?

- As a courtesy to you we will help you process all insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefit ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care of our financial policy.

I have read, understand and agree to the above terms and conditions.

Signature____ Date_______________________________

Richard Bowen, DDS
Taryn Gehlert, DDS
General, Cosmetic & Implant Dentistry

www.bowenlegacydental.com
Tel: 614-459-2300
770 Jasonway Ave.
Columbus, OH 43214

Acknowledgement of Receipt of Notice of Privacy Practices

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

Signature______________________________________ Date___________________________

You may refuse to sign this acknowledgement
Refusing______________________________________ Date___________________________

HIPAA Release of Information

I, ________________________________, authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

- ☐ Spouse_____________________________________
- ☐ Child(ren)__________________________________
- ☐ Other_______________________________________
- ☐ Information is not to be released to anyone.

This release of information will remain in effect until terminated by me in writing.

Messages

Please call: ☐My home ☐My work ☐My cell

If unable to reach me:

- ☐ You may leave a detailed message.
- ☐ Please leave me a message asking me to return your call.

The best time to reach me is (day)________________________________between (times)_____________________________

Signature______________________________________ Date______________________________

Witness_______________________________________ Date______________________________