Brian R. Bowman DDS, PLLC
FAMILY DENTAL CARE

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PATIENT INFORMATION

Welcome to the dental office of Brian R Bowman DDS. We appreciate the confidence you have placed in us for providing you with dental services. To best assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. Please keep us informed of any recent changes in your health. Thank You.

Patient Name:_____Date of Birth:_____Sex:_____

Home Address:_____City:_____State:_____Zip:_____

Billing Address (if different)_____

Home Phone:_____Cell:_____

E-Mail:_____Driver's license#:_____WA:_____

SS#:_____Spouse's name & phone#:_____

Employer _____Work Ph #_____

Emergency name and phone#_____Relationship:_____

How may we confirm your appts? Personal phone call☐ Text message☐ E-mail☐ Recorded phone message☐

Who may we thank for referring you to us?_____

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE

Subscriber's name_____ Subscriber's DOB_____

Ins. ID#_____ Insurance Company_____

Group #:_____ Name of Employer_____

SECONDARY INSURANCE

Subscriber's name_____ Subscriber's DOB_____

Ins. ID#_____ Insurance Company_____

Group #:_____ Name of Employer_____

I certify that I am not receiving DSHS/APPLE Medical Assistance and I agree to pay for the services. If I later become eligible for DSHS Medical Assistance, I agree to notify the provider's billing office.

Signature_____Date_____Relationship (if other than patient)_____

ASSIGNMENT AND RELEASE:

I hereby authorize benefit payments from my dental Insurance Company to be paid directly to the dentist. I understand that I am responsible for any balances due. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals as necessary. The information on this page and the dental/medical histories are correct to the best of my knowledge.

Signature:_____Date:_____