HENRY B. BOWMAN, DDS
GENERAL DENTISTRY

Henry B. Bowman, DDS
5 Greenway Plz # C980
Houston, TX 77046
713-961-9894

New Patient Form

Please fill out all the information to the best of your knowledge. All answers will be kept confidential. If you have any questions, please ask us, and we'll be happy to assist you.

Date: / /

Patient #:

Patient Information

Title:	First Name:	Last Name:	I prefer to be called:

Sex:	Age:	Date of Birth (mm/dd/yyyy): / /	Marital Status:

Home Phone: - -	Work Phone: - -	Cell Phone: - -	E-mail Address:

Home Address:	City:	State:	ZIP Code:

Employment:	Employer's Name:	Employer's Phone: - -	Occupation:

Employer's Address:	City:	State:	ZIP Code:

Student Status:	School Name (if a full-time student):	Grade:

Best places and times to contact you:

Send appointment reminders via:
❑ Text Message ❑ Email ❑ Mail

Please tell us where you heard about us (check all that apply):
❑ Friend or Relative (name): ❑ Newspaper Ad ❑ Radio Ad ❑ TV Ad
❑ Ad in Mail ❑ Saw our Office ❑ Insurance Company ❑ Our Website
❑ Search Engine (Google, etc.) ❑ Other Website:
❑ Other:

Was our website a factor in your decision to visit our practice? ○ Yes ○ No

Name of Spouse (or Parent, if a minor):	Spouse/Parent's Employer:	Spouse/Parent Work Phone: - -	Spouse/Parent Cell Phone: - -

Other family members treated by us:	Additional Comments:

Emergency Contact

Title:	Relationship to Patient:

Home Phone: - -	Work Phone: - -	Cell Phone: - -	E-mail Address:

Emergency_Contact Address:	City:	State:	ZIP Code:

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Person Responsible for Account

Title:	First Name:	Middle Name:	Last Name:	Relationship to Patient:

Date of Birth (mm/dd/yyyy):	Social Security #:	Driver's Licence State & #:	Holder of Dental Insurance for Patient:
/ /	- -		

Home Phone:	Work Phone:	Cell Phone:	E-mail Address:
- -	- -	- -	

Billing Address:	City:	State:	ZIP Code:

Employment:	Employer's Name:	Employer's Phone:	Occupation:
		- -	

Employer's Address:	City:	State:	ZIP Code:

Insurance Information

Primary Insurance

Insurance Holder's Name:	Date of Birth (mm/dd/yyyy):	Relationship to Patient:	Employer:
	/ /		

Member ID:	Group ID:	Insurance Company Name:	Insurance Company Phone:
			- -

Insured's SSN:	Insurance Company's Address:	City:	State:	ZIP Code:

Secondary Insurance

Insurance Holder's Name:	Date of Birth (mm/dd/yyyy):	Relationship to Patient:	Employer:
	/ /		

Member ID:	Group ID:	Insurance Company Name:	Insurance Company Phone:
			- -

Insured's SSN:	Insurance Company's Address:	City:	State:	ZIP Code:

Authorization

All of the above information is correct to the best of my knowledge. I authorize use of this form on all my insurance submissions and I authorize the release of information to all my insurance companies. I understand that I am responsible for my bill. I authorize Dr. Brown to act as my agent in helping me to obtain payment from my insurance companies. I authorize payment to Dr. Brown. I permit a copy of this authorization to be used in place of the original. I give Dr. Brown, its employees, and/or other agents express prior consent to contact me at any/all phone numbers, including cell numbers (by phone call or text message) and email addresses, for the purpose of treatment, insurance, or payment.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy):
	/ /

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Primary Reason For Visiting the Dentist Today: _____

Dental History - Please Circle One (Yes or No):

1) Are you feeling any pain at the moment?	YES	or	NO
2) Do you feel nervous about visiting the dentist?	YES	or	NO
3) Have you ever had a bad experience ina dental clinic?	YES	or	NO
4) Is there something you don't like about your smile?	YES	or	NO
5) Have you ever received proper instruction on tooth hygiene and gum care?	YES	or	NO
6) Is there any infammation or sores in your mouth or on your gums?	YES	or	NO
7)Do you have any problems chewing?	YES	or	NO
8) Does food normally get stuck between your teeth?	YES	or	NO
9)Are you aware, or have you ever been told, that you grind your teeth while you sleep?	YES	or	NO
10) Do you feel like you've been told that you ahve bad breath?	YES	or	NO
11) Do your gums bleed easily?	YES	or	NO
12) Do you clench your teeth?	YES	or	NO

Medical History - Please Circle Any of the Following That You Have Had, or Have at Present

Cardiac/Heart Attack	Cancer (Type:_____)	Fainting or Dizziness	Any Type of Implant
Heart Murmur	Kidney Disease	Sickle Cell Disease	Any Type of Transplant
Angina Pectoris	Ulcer	HIV Positive/AIDS	Any Artificial Prosthesis
Mitral Valve Prolapse	Use of Tobacco Products	Alcoholism	Allergic To (List All):
High Blood Pressure	Emphysema	Drug Addiction	_____
Rheumatic Fever	Tuberculosis	Glaucoma	_____
Congential Heart LEgions	Asthma	Cortisone Treatments	_____
Pacemaker	Sinus Problems	Hepatitis (Type:_____)	_____
Heart Surgery	Hay Fever	Liver Disease	Take Medication (List All):
Anemia	Diabetes	Jaundice	_____
Stroke	Radiation Treatment	Blood Transfusion	_____
Epilepsy or Seizures	Chemotherapy	Blood Disorders	_____
Psychiatric Treatment	Arthritis	Herpes	_____

For Women Only - Are you pregnant? (YES or NO), If Yes, How Long? _____ | Are You Nursing: (YES or NO)

I certify that all information provided by me on this form is true, correct, and answered to the best of my ability. If there is any change in my health, allergies, or medication, I will inform the doctor prior to treatment.

Patient Signature: _____ Date: _____

Office Representative Signature: _____ Date: _____