

ROWAN FAMILY DENTISTRY

Dr. Kevin Rowan, DMD 717 Coulter Drive New Albany, MS 38652 Dr. Kara Miles Rowan, DMD

PATIENT INFORMATION

HOME PHONE: _____ **CELL PHONE:** _____

Patient's Name _____

Referred By _____

Mailing Address _____

City _____ **State** _____ **Zip** _____

Physical Address _____

City _____ **State** _____ **Zip** _____

Social Security Number _____

Date of Birth _____ **Age** _____ **Male** _____ **Female** _____

Marital Status:

Single _____ **Married** _____ **Separated** _____ **Divorce** _____ **Widowed** _____

Full Time Student? Yes ___ **No** ___

If yes, where _____

City _____ **State** _____

EMPLOYMENT

Place of Employment _____

Phone Number _____

Name of Spouse _____

Social Security Number _____ **Date of Birth** _____

Spouse's Place of Employment _____

Phone Number _____

DENTAL INSURANCE COVERAGE INFORMATION

Name of Insurance Company _____

Phone Number _____

Name of Policy Holder _____

Social Security Number _____ **Date of Birth** _____

We file insurance as a courtesy to our patients. We will ensure you get the maximum benefit from your insurance. In the event that the insurance doesn't pay as much as we expected or at all, you the patient are responsible for the total bill. Thank you for your understanding.

PARENT INFORMATION

Father's Name _____
Social Security Number _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
Phone # _____ Cell # _____
Father's Place of Employment _____
Phone Number _____
Mother's Name _____
Social Security Number _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
Phone # _____ Cell # _____

Mother's Place of Employment _____
Phone Number _____
Person responsible for payment of account. _____
Phone # _____ Cell # _____
In Case of emergency who can we contact? _____
Phone # _____ Cell # _____

HEALTH HISTORY

Is the patient now in good health? Yes ___ No ___
Does patient have a history of any major illness? Yes ___ No ___
If Yes, Please explain _____

Has the patient ever been under the care of a physician for illness?

YES	NO		YES	NO	
___	___	Arthritis	___	___	Hepatitis or Jaundice
___	___	Prolonged Bleeding	___	___	Liver Disease
___	___	Rheumatic Fever	___	___	Cancer or Tumor
___	___	Fainting Tendency	___	___	Tuberculosis
___	___	Heart Trouble	___	___	Diabetes
___	___	Epilepsy	___	___	Kidney/Bladder Trouble
___	___	Heart Murmur	___	___	Anemia
___	___	Glaucoma	___	___	Lung Disease
___	___	High/Low Blood Pressure	___	___	Venereal Disease
___	___	Radiation Treatment	___	___	Sinus Trouble
___	___	Chest Pain			
___	___	Mental Disorders			
___	___	Stroke			
___	___	HIV or AIDS			
___	___	Shortness of Breath			
___	___	Prosthetic Joint Replacement			
___	___	Asthma or Hay Fever			
___	___	Blood Transfusion			

List any Drugs or Medications now being taken.

Give reasons. _____

Please circle if you are taking one of these medications.

Aredia Actonel Zometa Fosamax

LIST ANY DRUG SENSITIVITY. _____

Physician: _____

The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make through diagnosis of the patient's dental needs. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use appropriate medication and therapy decided for such treatment in connection with (name of patient) _____. I understand that using anesthesia agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistants as deemed fit to provide recommended treatment. I understand that all responsibility for payment for dental services provided in this office for myself or my Dependants are mine, due and payable at the time services are rendered unless other arrangements have been made.

(Please Sign)

In the event payments are not received by the agreed upon date, I understand that 1-1/2% finance charge (18% APR) may be added to my account and that I will be responsible for all collection charges that may be charged in addition to my fee for dental services.

Patient _____

Date _____ Witness _____

Patient _____ Relationship to

Patient _____

Are you Happy with your Smile? _____

Is there anything you would like to change about your Smile?

_____Whitening

_____Straightened_____ Bonding_____ Veneers_____ Partial_____New Denture