ROWAN FAMILY DENTISTRY

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

PATIENT INFORMATION

HOME PHONE:_____ CELL PHONE:_____
Patient's Name _____
Referred By_____

Mailing Adddress_____
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			
___	___	Rheumatic Fever	___	___	Liver Disease
___	___	Fainting Tendency			
___	___	Heart Trouble	___	___	Cancer or Tumor
___	___	Epilepsy			
___	___	Heart Murmur	___	___	Tuberculosis
___	___	Glaucoma			
___	___	High/Low Blood Pressure	___	___	Diabetes
___	___	Radiation Treatment			
___	___	Chest Pain	___	___	Kidney/Bladder Trouble
___	___	Mental Disorders			
___	___	Stroke	___	___	Anemia
___	___	HIV or AIDS			
___	___	Shortness of Breath	___	___	Lung Disease
___	___	Prosthetic Joint Replacement			
___	___	Asthma or Hay Fever	___	___	Venereal Disease
___	___	Blood Transfusion	___	___	Sinus Trouble

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_____Partials_____New Denture