RICHARD ROWAN, D.M.D., M.S.D., A.B.O.

BOARD CERTIFIED ORTHODONTIC SPECIALIST

PATIENT INFORMATION

Date_____ Age _____ School _____ Hobbies _____

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Birthdate _____ Soc. Sec. No. _____

Best time to phone _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION

Name _____
Last First Middle Marital Status

Address _____
Street City State Zip

Own _____ Rent _____ Living with Relative _____

How long at this address? _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 years) _____
Street City State Zip

Soc. Sec. No. _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____
Last First Middle

Spouse's Employer _____

Occupation _____ No. Years Worked _____ Work Phone _____

INSURANCE INFORMATION

Insured's Name _____ Insured's Soc. Sec. No. _____ D.O.B. _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Company Address _____

Do you have dual coverage? Yes ____ No ____ If Yes:

Insured's Name _____ Insured's Soc. Sec. No. _____ D.O.B. _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Company Address _____

Insured's Employer _____

I have read and received a copy of this office's Notice of Privacy Practices (HIPPA).

Signed _____ Date _____

I have reviewed the following treatment plan. I authorize release of any information relating to this claim.

Signed _____ Date _____
Patient or Parent of Minor

I hereby authorize payment directly to the below-named dentist of the group insurance benefits otherwise payable to me.

Signed _____ Date _____
Signed (Insured Person)

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete Address _____ Phone _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

Updates (dates & initial) _____ _____ _____ _____ _____

Have you been to an orthodontic office before? _____

Dentist _____ Dental Cleaning/Last Exam _____

In your opinion, what is wrong with your teeth? _____

_____

Patient's concern _____

Patient's attitude _____

Do you mind having braces? _____

Any injuries to your jaw? _____ Teeth ? _____ When? _____

Father's height? _____ Mother's height? _____ Patient's height? _____

Resembles? _____ Growth past year? _____ Adopted? _____

Siblings/Children? _____

_____

Present Health: Excellent _____ Good _____ Fair _____ Poor _____

Medical History - Do you have or have you ever had any of the following:

	Yes	No		Yes	No		Yes	No
Anemia	_____	_____	Abnormal Heart Condition?	_____	_____	Allergies to:		
Asthma	_____	_____	Abnormal Blood Pressure?	_____	_____	Penicillin	_____	_____
Diabetes	_____	_____	Tendency to Colds	_____	_____	Local Anesthetic	_____	_____
Epilepsy	_____	_____	Sore Throats	_____	_____	Medication or Drugs	_____	_____
Hepatitis	_____	_____	Ear Infections	_____	_____	Have you ever fainted?	_____	_____
Rheumatic Fever	_____	_____	Thumb or finger habits?	_____	_____	Difficulty in Chewing	_____	_____
Pregnant?	_____	_____	Jaw pain or discomfort?	_____	_____	Swallowing	_____	_____
Orthodontic considerations:			Nail biting	_____	_____	Injuries to teeth or face	_____	_____
HIV	_____	_____	Speech	_____	_____	Tongue Thrusting	_____	_____
Hepatitis	_____	_____				Mouth Breathing	_____	_____
Herpes	_____	_____				Latex	_____	_____

If allergic to medication or drugs, indicate which ones _____

Are you taking any medication? If so, for what? _____

Ever been hospitalized? _____ For what? _____

Name of physician _____ Address _____

Name of dentist _____ Address _____

Do you anticipate a move or transfer in the near future? _____