Rowe & Rowe Smile Studio

Patient Information

Patient's First Name:________________________________ Last Name:____

Address: ____ City:____

State/Zip:_______________________________________ Home Phone: (_____)_______________________________

Work Phone: (_____)______________________________ Cell Phone: (______)_______________________________

Birth Date:______/_____ /_____ Age: ________ Social Security #:______-_____-______ Sex: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Spouse or Responsible Party Information

The following is for: ☐ patient's spouse ☐ person responsible for payment (If other than patient)

First Name:_______________________________________ Last Name:____

Address: ____ City:____

State/Zip:_______________________________________ Home Phone: (_____)_______________________________

Work Phone: (_____)______________________________ Cell Phone: (______)_______________________________

Birth Date:______/_____ /_____ Age: ________ Social Security #:______-_____-______Age: ________

Employment/School Information

The following is for: ☐ the patient ☐ the person responsible for payment (If other than patient)

Employer Name: ____

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Address: ____ Phone number :(_____)___________________

The following is for: ☐ the patient ☐ the person responsible for payment (If other than patient)

Student Status: ☐ Full Time ☐ Part Time School Name:____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient If so, whom?_________________________

☐ Television ☐ Magazine ☐ Yellow Pages ☐ Other______________________

Dental Information

Reason for visit today:____

Approximate date of last dental visit: _______________ Are you happy with your smile? ___________________________

On a scale from 1-10, how would you rate your teeth? 1 2 3 4 5 6 7 8 9 10 (perfect)

What would make them a "10"? ____

Consent: I agree to allow Dr Rowe to use photographs of my teeth and face for educational and/or marketing purposes.

____ __________

Signature of patient/parent or guardian Date

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Primary Dental Insurance Information

Insurance Company

Name:______________________ Phone Number: (_____)______________

Address:______________________ City:______________________

State/Zip:__________________ Annual Benefits:__________ Yearly Deductible:__________

Insured

First Name:__________________ Last Name:__________________

Birth Date:______/_____ /_____ Social Security #:______-_____-______

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other _____________

Insured's Employer

Name: ____

Address:____

City:________________ State/Zip:________________ Phone Number: (_____)______________

Secondary Dental Insurance Information
(If Applicable)

Insurance Company

Name:______________________ Phone Number: (_____)______________

Address:______________________ City:______________________

State/Zip:__________________ Annual Benefits:__________ Yearly Deductible:__________

Insured

First Name:__________________ Last Name:__________________

Birth Date:______/_____ /_____ Social Security #:______-_____-______

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other _____________

Insured's Employer

Name: ____

Address:____

City:________________ State/Zip:________________ Phone Number: (_____)______________

I authorize direct payment of any dental benefits to this office for services rendered. I authorize the release of necessary information to my insurance companies if they require such for claim payments.

______________________________ ______________________
Signature of patient/parent or guardian Date

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Patient Medical History

Patient Name ______________________________ Date of Birth: ______/______ /_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you have, or medication that you may be taking could have an important relationship with the dental treatment you receive. Thank you for answering the following questions so that we may better care for you!

Are you under a physicians care now? ______________________________

Have you ever been hospitalized or had a major operation? _________ If yes, please list:______________________

Have you ever had a serious head or neck injury? ______________________________

Are you taking any medication, pills, or drugs? _________ If yes, please list all medications:______________________

____

Do you, or have you ever taken, Phen-Fen or Redux? ______________________________

Do you use any type of tobacco? ______________________________

Women- Are you…
Pregnant/trying to get pregnant?___________ Breast feeding?___________ Taking oral contraceptives?___________

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetic ☐ Other __________________

Do you have, or have you had any of the following?

Aids/HIV Positive	☐	Heart Pacemaker	☐
Artificial Heart Valve	☐	Heart Trouble/Disease	☐
Artificial Joint	☐	Hemophilia	☐
Asthma	☐	Hepatitis A	☐
Blood Disease	☐	Hepatitis B or C	☐
Blood Transfusion	☐	Herpes	☐
Breathing Problems	☐	High Blood Pressure	☐
Chest Pains	☐	Hypoglycemia	☐
Cold Sores/Fever Blisters	☐	Irregular Heartbeat	☐
Congenital Heart Disorder	☐	Liver Disease	☐
Diabetes	☐	Low Blood Pressure	☐
Drug Addiction	☐	Lung Disease	☐
Epilepsy/Seizures	☐	Mitral Valve Prolapse	☐
Excessive Bleeding	☐	Pain in Jaw Joint	☐
Excessive Thirst	☐	Psychiatric Care	☐
Frequent Headaches	☐	Stroke	☐
Heart Attack/Failure	☐	Tuberculosis	☐
Heart Murmur	☐	Ulcers	☐

Have you ever had any serious illnesses not listed above?______________________________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my/the patient's health. It is my responsibility to inform the dental office of any changes in my/the patient's medical status.

______________________________ ________________
Signature of patient/parent or guardian Date

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Important Information

HIPAA Policy

I understand that, under the Health Insurance Portability & Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information may be used to:

- Conduct, plan, and direct my treatment and follow-up among multiple healthcare providers who may be involved in treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations.

I understand that, upon request, I have the right to receive a complete copy of your Notices of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this office has the right to change its Notices of Privacy Practices from time to time if necessary and that I may contact this office at any time to obtain a current copy.
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree to them you are bound to abide by such restrictions.

______________________________________ ________________
Signature of patient/parent or guardian Date

Financial Agreement

I understand that I am financially responsible for the services rendered to me by this office. I understand that any accounts that are over 90 days past due may be turned over to a third party collection agency. If the account has to be turned over to a third party collection agency or attorney, I understand that I will be responsible to pay all collection expenses incurred including any agency fees, litigation expenses, court costs, and/or reasonable attorney fees. I also understand and agree to pay a $15.00 service charge for any returned checks.

______________________________________ ________________
Signature of patient/parent or guardian Date

***We strongly dislike doing this and will only do so if all other efforts to collect the unpaid balance have failed. If an account has to be turned over to collections, we will ask that you seek the services of another dentist, and unfortunately we will no longer take responsibility for your family's dental care.

Insurance Agreement (for clients with dental insurance)

As a courtesy to our clients with insurance, we will be happy to take care of all the necessary paperwork associated with filling out your insurance claim. We will do everything that we can to maximize your dental insurance.
I understand that my dental insurance is a contract between me and my insurance company, and the total balance for any necessary treatment is my responsibility.

______________________________________ ________________
Signature of patient/parent or guardian Date