DR. ROBERT B. ROWEN, D.M.D., PA

Patient Name: ____

Gender: ☐ Male ☐ Female **Family Status:** ☐ Married ☐ Single ☐ Child ☐ Other

Date of Birth: ____/____/______ **Social Security Number:** ______-______-______
For Dental Insurance purposes only

Address: ____

City: ____________________________ **State:** __________________________ **Zip:** ___________

Home Phone: ___________________________ Cell Phone: ___________________________

Work Phone: ____________________________ Alt. Phone: ___________________________

Email Address: ____
Your email will not be sent/sold to third parties! This is only so we can reach you!

Preferred Method of Contact: ☐ Home ☐ Cell ☐ Work ☐ Alt. ☐ Email

In case of Emergency: *Name:* ___________________________ *Relation:* _________________
Phone Number: ____

Whom may we thank for referring you to our practice? ________________________________

Medical History

Patient Name: ____ **Date:** _________________

Date of last dental exam: _____/_____/_____ **Date of last Medical exam:** ____/____/____

Weight: _______lbs. **Height**: _________

Please list your current medications (or provide list to front desk): _______________________________
____
____

Please list any medication allergies: ____
Are you currently under medical treatment? ☐ YES ☐ NO
If yes, who is your treating physician? ___________________________________ Ph. (_____)____________
Who is your primary care physician? ____________________________________ Ph. (_____)____________

Are you currently taking any of the medications listed below?
☐ Coumadin ☐ Plavix ☐ Bisphosphonate Drugs (Fosamax)

Have you had any of the following:

Condition	YES	NO	
Heart Surgery, Disease, Attack, Murmur	☐ YES	☐ NO	When? ___________________________
Rheumatic Fever	☐ YES	☐ NO	When? ___________________________
Shortness of breath – chest pain	☐ YES	☐ NO	When? ___________________________
Mitral Valve prolapse – artificial valve	☐ YES	☐ NO	When? ___________________________
Pacemaker	☐ YES	☐ NO	When? ___________________________
High Blood Pressure	☐ YES	☐ NO	When? ___________________________
Stroke	☐ YES	☐ NO	When? ___________________________
Arthritis/Rheumatism	☐ YES	☐ NO	
Cortisone Medicine	☐ YES	☐ NO	
Swollen ankles	☐ YES	☐ NO	
Anemia/Anemic	☐ YES	☐ NO	
Fainting or Dizziness	☐ YES	☐ NO	
Diabetes	☐ YES	☐ NO	
Ulcers	☐ YES	☐ NO	
Thyroid or Kidney Problems	☐ YES	☐ NO	When? ___________________________
Liver Disease or Jaundice	☐ YES	☐ NO	When? ___________________________
Hepatitis	☐ YES	☐ NO	When/What Type? __________________
Glaucoma	☐ YES	☐ NO	
Tumor or Cancer	☐ YES	☐ NO	Treated? __________________________
Chemotherapy	☐ YES	☐ NO	
Radiation Therapy	☐ YES	☐ NO	

Patient Name: ____

Tonsil or Adenoid Problems	☐ YES	☐ NO	
Smoke or Tobacco Use	☐ YES	☐ NO	How often: ________________________
Alcohol Drinks	☐ YES	☐ NO	How often: ________________________
A.I.D.S.	☐ YES	☐ NO	
H.I.V. Positive	☐ YES	☐ NO	
Blood Disorder	☐ YES	☐ NO	What type: ________________________
Hemophilia	☐ YES	☐ NO	
Auto-Immune Disease	☐ YES	☐ NO	
Are you still paying attention?	☐ YES	☐ NO	
Nervous or Anxious Disorders	☐ YES	☐ NO	What type?__________________________
Neurological Disorder	☐ YES	☐ NO	
Epilepsy or Seizures	☐ YES	☐ NO	
Fatigue Easily	☐ YES	☐ NO	

SLEEP APNEA:

Do you sleep well?	☐ YES	☐ NO
Do you snore?	☐ YES	☐ NO
Trouble breathing when sleeping?	☐ YES	☐ NO
Sleep with elevated bed?	☐ YES	☐ NO
Do you sleep with more than 2 pillows?	☐ YES	☐ NO

Please list any major surgeries and year done (this includes any artificial valve/joint/knee/hip replacements): ____

____

____

List any other pertinent medical information that has not been previously listed/covered: ______________

____

FOR WOMEN: If currently pregnant, when is your expected delivery date: ____________________________

OBGYN's Name: __________________________________ Phone Number: ___________________________

Please fill out, only if currently pregnant; this is to get medical clearance for any treatment

Authorization: I hereby authorize Dr. Robert Rowen and/or staff of Rowen Dentistry to administer such medications and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care as agreed upon through consultation with me. The information I have provided on my medical/dental histories is correct to the best of my knowledge. I also authorize Dr .Robert Rowen and/or Staff of Rowen Dentistry to contact my healthcare provider(s) concerning my treatment if necessary.

Patient Signature: ____ Date: ___________________

Or Parent or Guardian Signature if patient is under 18 years old

DENTAL INSURANCE

Policy Holder Name: ______________________________ Date of Birth: ____/____/_______

Policy Holder ID Number: ____

Dental Insurance Company: ____

Dental Insurance Phone Number: ____

Employer Name: _______________________________ Group Number: ________________

As a courtesy, Rowen Dentistry submits dental claims to the patient's dental insurance company on the patient's behalf. However, it is the patient's responsibility to know what their dental insurance plan covers.

Eligibility information and benefits provided at this time by my dental insurance is based upon the information available at this time and is subject to all plan provisions. **This is not a guarantee of payment. Final liability, if any, cannot be determined until the claim is received, reviewed and processed**. Therefore, the patient will be responsible for any balance remaining on the account.

Most insurances downgrade crowns, fillings, etc. This means, they will only pay a portion of a lower grade crown/bridge or amalgam (silver-colored) filling. I have been informed by the office that Dr. Robert Rowen only uses resin (tooth colored) material for fillings and the upper grade (tooth colored) crowns/bridges. The patient will be responsible for the difference. Additionally, most insurance companies **DO NOT COVER EVERYTHING**. It is the patient's responsibility to know what their plan does/does not cover.

Please list any family members that are under the same dental insurance:

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____

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Financial Agreement

The undersigned acknowledges that we are a fee for service office. Payment is due when services are rendered. All accounts are due and payable within 30 days of an invoice date. An interest charge of 1.5% per month will be applied to any unpaid balance after thirty (30) days. In the event this account is in default, customer agrees to pay all cost of collection, including court costs and attorney fees, whether suit is filled or not. In the event suit is filed, venue will be Broward County, Florida.

I have read and understand the above statements. All questions or concerns were answered for me.

Patient Signature: ____ Date: _________________
Or Parent/Guardian Signature (if patient is under 18 years old)

Witness: ____

LATE/CANCELLATION POLICY

We value your time as well as our own.

We **always** try our best to stay on time for your appointment.

As a courtesy, our staff will contact you at least 2 days prior to your appointment to confirm. We do require a confirmation or cancellation call/email **at LEAST 24 hours prior** to your appointment. If your appointment falls on a Monday, you will need to confirm no later than 11:30am on the previous Friday.

When we schedule appointments, we set aside time and professional resources to meet the individual needs of our patients. When a patient fails to show up for an appointment or cancels within or less than 24 hours of the appointment, our valuable resources are idle. More importantly, a patient care opportunity is missed.

If you do not show up or **cancel your appointment without giving 24 hour notice**, **a $25 cancellation fee** may apply. The fee could be more, depending on the amount of time we had reserved for you. We understand that there are times when a patient must miss an appointment due to unforeseen circumstances or a scheduling conflict is beyond his or her control. We ask that you call our office to cancel/reschedule your appointment as soon as possible. This courtesy allows our staff to schedule another patient who is also in need of dental care. Repeated late/same day cancellations or no shows will result in a fee which must be paid prior to any future visits.

If you are late for your appointment, we reserve the right to reschedule your appointment to ensure proper time for treatment.

I have read and understand the above statement. All questions or concerns were answered for me. I understand that confirming/rescheduling/cancelling my appointments are my responsibility.

Patient Name (Print): ____ Date: ______________________

Patient Signature: ____

Or Parent/Guardian Signature (if patient is under 18 years old)

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

* You May Refuse To Sign This Acknowledgement*

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the health insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in the treatment directly and indirectly.
- Obtain insurance benefits via your Dental Insurance Company (if applicable)
- Obtain payment from third-party payers for my health care services.
- Discuss health treatment with your treating doctors that may affect treatment needed.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's Notice of Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a current copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices.

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 understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ____ Date: ______________________

Patient Signature: ____
Or Parent/Guardian Signature (if patient is under 18 years old)

If Parent/Guardian Signature, relation to patient: ____

Please list any family members also covered by this acknowledgment:

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