# -WELCOME-
# Dr. Robert Rowland's Office

## PATIENT INFORMATION

Date_____ Email (optional)_____

__ I would like to receive email or text messages regarding future appts.

Name _____ Birth date_____

Address _____City _____State _____ Zip _____

Home Phone# _____Cell Phone#_____ SS# _____

**RESPONSIBLE PARTY OR POLICY HOLDER – (IF DIFFERENT THAN ABOVE)**

Name _____ Birth date_____

Address _____City _____State _____ Zip _____

Home Phone# _____Work Phone#_____ SS # _____

**DENTAL INSURANCE**

Employer _____ Ins Company _____ ID # _____

## DENTAL HISTORY

Name of Previous Dentist _____ Date of last exam _____

| Yes | NO | | Yes | NO | |
|---|---|---|---|---|---|
| ___ | ___ | Have you ever experienced any of the following problems in your jaw? | ___ | ___ | Are your teeth sensitive to hot or cold liquids/foods? |
| ___ | ___ | --clicking? | ___ | ___ | Are your teeth sensitive to sweet or sour liquids/foods? |
| ___ | ___ | --pain (joint, ear, side of face)? | ___ | ___ | Have you had any orthodontic treatment (braces)? |
| ___ | ___ | --difficulty with opening, closing, or chewing? | ___ | ___ | Do you clench or grind your teeth? |
| ___ | ___ | Do you feel pain in your teeth? | ___ | ___ | Do your gums bleed while brushing or flossing? |
| | | | ___ | ___ | Do you have any sores or lumps in your mouth? |

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## AUTHORIZATION AND RELEASE

-I agree to be responsible for payment on all services rendered on my behalf or my dependents.
- I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners.
-If filing dental insurance, I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. **I understand that my dental insurance carrier may pay less than the actual bill for services. I understand that I am responsible for those charges not paid by my insurance company.**
-I have read and understand this office's Notice of Privacy Practices.

_____ _____

Patient's Signature (Parent or Guardian) Date