Nicholas B. Rowley D.M.D.

205 W New Haven Ave
Melbourne, FL 32901

** **Whom may we thank for referring you to our office**?_____
☐ Online ☐ Sign ☐ Ins. Plan ☐ Word of Mouth ☐ Other _____

Patient Information

Patient Name: _____ Date:_____
Last First MI (Preferred Name)

Address: _____
Street Apartment #

_____
City State Zip Code

Birth Date: _____ Gender: Male _____ Female _____ Family Status: Married ___Single ____Child ___Other ___

Social Security #: _____ Drivers License #_____Best time to call: AM PM

Phone (Home):_____(Work):_____ Ext: _____(Cell)_____

E-Mail Address _____

Who should be notified in case of emergency?_____Phone#_____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Any Time ☐M ☐Tu ☐W ☐Th

Health Information

Date of Last Dental Visit: _____ **Reason for this visit:** _____

Have your ever had any of the following? Please check those that apply:

- ☐ A.I.D.S.
- ☐ Allergies _____
  _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ H.I.V. Positive
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Premedication for Dental Appts

_____

OTHER:

- ☐ _____
- ☐ _____

· Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

· Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: _____

· Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain: _____
_____

· Name of Physician: _____ Phone: _____

· Are you taking any medications? ☐ Yes ☐ No
If yes, please list: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____
Patient (Print Name)

_____ Date: _____
Signature of patient, parent or guardian

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____

Street Apartment #

_____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name:_____ Occupation: _____

Address: _____

Street City , State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ SS #: _____ Group #: _____

Insurance Company: _____

Name Street City State Zip Code

Insured's Employer Name: _____

Address:

_____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ SS #: _____ Group #: _____

Insurance company: _____

Name Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Consent for Services

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient)_____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

I have read the above conditions of treatment and agree to their content.

Patient _____

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian