Rowan Family Dentistry

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(662)534-4397

Welcome to the Practice

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Driver License# _____

How did you hear about our office?

☐ Billboard ☐ Postcard/Brochure ☐ Facebook ☐ Internet/Website/Google ☐ Insurance Referral
☐ Magazine ☐ Radio ☐ TV ☐ Newspaper

Name of person, office, or other provider referring you to our practice:

_____

In an emergency who should be notified? Please enter Name and Phone number below:

Emergency Contact: *

_____

_____

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Responsible Party Information:

This only needs to be filled out if the insurance subscriber is other than patient, or you are the parent/guardian of the patient

The following is for:* ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____* _____* ____ _____
Last First MI Preferred Name

Title: _____ **Gender:*** ◯ Male ◯ Female **Family Status:*** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date:* _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____* _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____* _____
Address 1 Address 2

_____* _____* _____-____*
City State Zip Code

Primary Dental Insurance:

Name of Insured: _____ _____ ____
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insurance Company Phone Number:

Secondary Dental Insurance:

Name of Insured: _____ _____ ____
Last First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Company Phone Number:

Insurance/Financial Responsibility

I acknowledge that I have received a copy of the financial policy acknowledgement.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Notice of Privacy Practices.

USES AND DISCLOSURES OF HEALTH INFORMATION

I hereby authorize and consent to the release of all dental, medical and personal information (including but not limited to my home phone, cell phone, work phone, address and email address) by or to any and all healthcare professionals involved in my care; Interpretation of test results; account billing and collections; payment posting and/or processing; or related healthcare functions. This authorization shall remain in effect until such time as all account balances extending from the encounter have been fully satisfied.

I authorize Rowan Family Dentistry, Inc. and all clinical providers who have provided care, along with any billing service and their collection agency or attorney who may work on their behalf, to contact me on my cell phone and/or home phone by electronic mail, text messaging or by any other form of electronic communication.

I authorize this office to disclose or discuss my personal and/or dental information with the following person(s).

(Please enter name and relationship to patient.)

There will be a $40.00 charge on all returned checks.

☐ * **I understand the above information and agree with its contents.**

Response Date: ____/____/_____