DR. MICHAEL W. ROWE
ORTHODONTIST

Please fill out this form completely in order for our office to prepare your clinical records.

Offices: ❒ St. Petersburg ❒ Largo ❒ Tampa ❒ Dade City

PLEASE PRINT

PATIENT INFORMATION

Today's Date ______________ ❒ Male ❒ Female

Name ______________________________
LAST FIRST M.I.

❒ Dr ❒ Mr ❒ Mrs ❒ Ms I prefer to be called __________

DOB ___/___/___ Age __________

SS # ___-___-___ DL # __________

Home Address ______________________________

____

Email Address ______________________________

Home # (___)________ Cell # (___)________

Work # (___)________ Ext __________

Employer ______________________________

Employer Address ______________________________

Occupation __________ How long there? __________

Preferred time/place to reach you __________

Who referred you to us? __________

Other family members we see? __________

Your General Dentist __________

Last visit to that dentist __________

SPOUSE INFORMATION

Spouse's Name ______________________________

SS # ___-___-___ DOB ___/___/___

Employer ______________________________

Work # (___)________ Cell # (___)________

EMERGENCY INFORMATION

In the event of an emergency, who should we contact locally?

Name ______________________________

Relation to Patient ______________________________

Home # (___)________ Work # (___)________

INSURANCE INFORMATION / PRIMARY

Orthodontic Coverage ❒ Y ❒ N Dental Coverage ❒ Y ❒ N

Insurance Co. Name ______________________________

Insurance Co. Address ______________________________

Insurance Co. Phone # (___)________

Group # (Plan #, Policy #) __________

Insured's Name __________ DOB ___/___/___

Relation to Patient __________ Insured's ID # __________

Insured's Employer ______________________________

INSURANCE INFORMATION / SECONDARY

Orthodontic Coverage ❒ Y ❒ N Dental Coverage ❒ Y ❒ N

Insurance Co. Name ______________________________

Insurance Co. Address ______________________________

Insurance Co. Phone # (___)________

Group # (Plan # or Policy #) __________

Insured's Name __________ DOB ___/___/___

Relation to Patient __________ Insured's ID # __________

Insured's Employer ______________________________

ACCOUNT RESPONSIBILITY

Person Responsible for Account __________

Relation ______________________________

Work # __________ Ext. Home # __________

Employer ______________________________

SS # ___-___-___ DL # __________

Insured's Name __________ DOB ___/___/___

Our practice is HIPPA Compliant and meets or exceeds the infection control standards mandated by OSHA, CDC & ADA.

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Medical History

Your current physicial health is ❐ Good ❐ Fair ❐ Poor

Are you currently under the care of a physician? ❐ Yes ❐ No

Explain ______

Are you taking prescription or over-the-counterdrugs?

❐ Yes ❐ No Please list: ______

______

Do you have a history or a current problem with:

Y	N	Abnormal Bleeding	Y	N	Hemophilia
Y	N	Anemia	Y	N	Hepatitis
Y	N	Artificial Bones / Joints / Valves	Y	N	High / Low Blood Pressure
Y	N	Asthma / Arthritis	Y	N	HIV+ / AIDS
Y	N	Blood Transfusion	Y	N	Hospitalized for Any Reason
Y	N	Cancer / Chemotherapy	Y	N	Kidney Problems
Y	N	Congenital Heart Defect	Y	N	Mitral Valve Prolapse
Y	N	Diabetes	Y	N	Psychiatric Problems
Y	N	Difficulty Breathing	Y	N	Radiation Treatment
Y	N	Drug / Alcohol Abuse	Y	N	Rheumatic / Scarlet Fever
Y	N	Emphysema	Y	N	Severe / Frequent Headaches
Y	N	Epilepsy / Seizures / Fainting	Y	N	Shingles
Y	N	Fever Blisters / Herpes	Y	N	Sickle Cell Disease / Traits
Y	N	Glaucoma	Y	N	Sinus Problems
Y	N	Heart Attack / Stroke	Y	N	Tuberculosis (TB)
Y	N	Heart Murmur	Y	N	Ulcers / Colitis
Y	N	Heart Surgery / Pacemaker	Y	N	Venereal Disease

Please list any serious medical condition(s) that you have ever had: ______

______

FOR WOMEN:

Are you using a prescribed birth control method? ❐ Yes ❐ No

Are you pregnant? ❐ Yes ❐ No

Are you nursing? ❐ Yes ❐ No

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Dental Anesthetics	Y	N	Penicillin
Y	N	Any Metal / Plastics	Y	N	Erythromycin	Y	N	Tetracycline
Y	N	Codeine	Y	N	Latex	Y	N	Other

Please list any other drugs / materials that you are allergic to: ______

______

______

Dental History

Your main concerns you would like orthodontics to accomplish?

______

______

Any serious problem with previous dental work? ❐ Yes ❐ No

Evaluated or had previous orthodontic treatment? ❐ Yes ❐ No

Previous or current pain / discomfort in jaw joint (TMJ / TMD)? ❐ Yes ❐ No

Your current dental health is ❐ Good ❐ Fair ❐ Poor

Do you like your smile? ❐ Yes ❐ No

Do your gums bleed? ❐ Yes ❐ No

Ever had an injury to your ❐ Mouth ❐ Teeth ❐ Chin

Do you have any speech problems? ______

Do you generally breathe through your mouth?
❐ Yes ❐ No While Awake? While Asleep? (please circle)

Any missing or extra permanent teeth? ❐ Yes ❐ No

Ever taken Fosamax or other biphosphonate? ❐ Yes ❐ No

Ever taken Phen-Fen? ❐ Yes ❐ No

Do you smoke or use any form of tobacco? ❐ Yes ❐ No

The information I have provided here is correct to the best of my knowledge. I understand this information will be held in the strictest confidence and that it is my responsibility to provide this office with any changes in my medical status.

I understand that ***I am responsible*** for any payment of services rendered, including any co-payments and deductibles, that my ***insurance does not cover***. I hereby authorize payment of these insurance benefits (otherwise payable to me) directly to this office. Also, if my insurance is terminated during active treatment, I am responsible for the balance.

______

Patient's Signature (or Legal Guardian) *Date*

FOR OFFICE USE ONLY

Medical and Dental information has been verbally reviewed with this patient. Initials ______ Date ______

Doctor's Comments: ______

______

______

______