Michael C. Rowland, DDS
2610 Moravian Avenue
Allentown, PA 18103
(610) 435-5707
ww.oraldynamics.com

PATIENT INFORMATION

Name: _____ Preferred Name: _____
Last First M.I.

Date of Birth: _____ Social Security #: _____ Male ____ Female ____
Month Day year

Address: _____City_____ST_____ZIP_____

Home Phone: _____ Cell: _____ Work: _____

E-Mail: _____To Receive Text Message Re: Appointments: Y☐ N☐

Marital Status: Married ___ Single ___ Minor ___ Who may we thank for this Referral: _____

Occupation: _____ Emergency Contact: _____
Name Phone #

MEDICAL Benefits Carrier: _____ ID#: _____ Group #: _____

Name of Benefits Subscriber: _____ Relationship:_____

Subscriber's Social Security #:_____ Subscriber DOB:_____

Employer of Subscriber: _____ Phone #: _____

Employer Address:_____ Have secondary medical benefits? Yes ___ No ___

REQUIRED Primary Care Physician:_____ Phone #:_____

DENTAL Benefits Carrier: _____ ID#: _____ Group #: _____

Name of Benefits Subscriber: _____ Relationship:_____

Subscriber's Social Security #:_____ Subscriber DOB:_____

Employer of Subscriber: _____ Phone #: _____

Employer Address:_____ Have secondary dental benefits? Yes ___ No ___

Authorization:
I hereby authorize payment directly to the Dental Office of the group dental benefits, otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

Patient Responsible Party Signature: _____ **Date:** _____

Driver's License #: _____ **State:** _____