LOWRY DENTAL, LLP

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About You

Today's Date ______/______/______

Patient Last Name ______________________________

Patient First Name ______________________________ MI ________

What You Prefer To Be Called ____________________ Male Female

Birth Date _____/_____/_____ Age ______ SS# ______________

Mailing Address ______________________________

____
City State Zip

If less than 3 years, previous address ______________________

____
City State Zip

☐ Rent ☐ Own

Home # (_____) ______________________________

Work # (_____) ______________________ Ext.__________

Cell # (_____) ______________________________

E-mail Address ______________________________

Referred By ______________________________

Employer ______________________ How Long __________

Occupation ______________________________

Status • Minor • Single • Married • Divorced • Separated • Widowed

Spouse's Name ______________________________

Spouse's Employer ______________________________

Account Information

Person ultimately responsible for account ☐ ***Check if same as above***

Name ______________________________

Relation ______________________________

Billing Address ______________________________

____
City State Zip

If less than 3 years, previous address ______________________

____
City State Zip

☐ Rent ☐ Own

Birth Date _____/_____/_____ Age ______ SS# ______________

Employer ______________________ How Long __________

Occupation ______________________________

Drivers License # ______________________________

Home # (_____) ______________________________

Work # (_____) ______________________ Ext.__________

Cell # (_____) ______________________________

Payment Method ☐ Cash ☐ Check ☐ Credit Card

Enter Card # below

______________________________ ______/______
Expiration Date

Insurance Information

Primary Dental Insurance

Co. Name ______________________________

Address ______________________________

____
City State Zip

Phone # (_____) ______________________________

Insured's ID # ______________________________

Group # (Plan, Local, or Policy #) ______________________

Insured's Name ______________________________

Relation ______________________________

Date of Birth _____/_____/_____

Insured's Employer ______________________________

Secondary Dental Insurance (If Applicable)

Co. Name ______________________________

Insured's ID # ______________________________

Group # (Plan, Local, or Policy #) ______________________

Insured's Name ______________________________

Relation ______________________________

Date of Birth _____/_____/_____

Insured's Employer ______________________________

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Signature ______________________________

In Event of Emergency

Whom Should We Contact? ______________________________

Relation ______________________________

Home # (_____) ______________________________

Work # (_____) ______________________ Ext.__________

Cell # (_____) ______________________________

Who Is Your Medical Doctor: ______________________________

Medical Doctor's Phone # (_____) ______________________

Please continue on Back

Medical History

Date of last cleaning/exam ______________________ Previous dentist______________________

Are you happy with your smile? ☐ Yes ☐ No *Please explain*______________________

Any concerns with your teeth? ☐ Yes ☐ No *Please explain* ______________________

Are you taking any medications? ☐ Yes ☐ No *Please list*______________________

Allergies ☐ Yes ☐ No *Please list*______________________

Serious illnesses or operations? ☐ Yes ☐ No *Please describe* ______________________

Have you experienced any unfavorable reaction to previous dental treatment? ☐ Yes ☐ No *Please describe*

____

Do you or have you had any of the following diseases, medical conditions or procedures: (please circle)

Y N Alcohol / Drug Abuse
Y N Anemia
Y N Arthritis / Rheumatism
Y N Artificial Bones / Joints
Y N Artificial Valves
Y N Asthma
Y N Back Problems
Y N Bleeding Problems
Y N Cancer / Tumors
Y N Chemotherapy
Y N Chest Pains
Y N Congenital Heart Defect
Y N Cosmetic Surgery
Y N Diabetes / Hypoglycemia
Y N Difficulty Breathing
Y N Emphysema
Y N Fainting / Seizures / Epilepsy
Y N Frequent Neck Pain
Y N Glaucoma
Y N Heart Attack / Stroke
Y N Heart Disease
Y N Heart Murmur
Y N Heart Surgery / Pacemaker
Y N Hepatitis
Y N High / Low Blood Pressure
Y N HIV+ / AIDS / ARC
Y N Jaw Problems TMJ / TMD
Y N Kidney Problems
Y N Leukemia
Y N Liver Problems
Y N Mitral Valve Prolapse
Y N Nervousness
Y N Osteoporosis
Y N Penicillin Allergy
Y N Pregnant (Currently)
Y N Psychiatric Problems
Y N Respiratory Problems
Y N Rheumatic Fever
Y N Scarlet Fever
Y N Severe / Frequent Headaches
Y N Shingles
Y N Sinus Problems
Y N Snoring or Sleep Apnea
Y N Stomach Problems / Ulcers
Y N Thyroid Problems
Y N Tobacco Use
Y N Tuberculosis TB
Y N Venereal Disease
Y N Xray or Cobalt Treatment

No Change ☐	Signature	Date	No Change ☐	Signature	Date
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Financial Policy

I authorize the release of treatment information to Lowry Dental, LLP. I have received a copy of the HIPAA privacy statement.

Payment is expected at the time treatment is performed. As a courtesy to our patients with dental insurance benefits, we will submit your claim to your insurance company. Any portion not expected to be covered by these benefits is the ***responsibility of the patient and due at the time the service is rendered***. This amount will include deductibles and co-payments.

Balances beyond 90 days will be assessed a finance charge of 1.50% per month with a minimum of $0.50.

Where appropriate and necessary, credit bureau reports will be obtained.

Dental benefits are contracts between the ***policyholder*** and the ***insurance company***. We will make every effort to assist you with any benefit questions, however we suggest that you be aware of what benefits you have available. Ultimately, you are responsible for the balance.

Marital status is not a consideration under any circumstance. Decreed custody or lack thereof, does not alter financial responsibility. The parent accompanying the child/minor on the day of service will be considered the responsible party. We will gladly provide you with copies of statements, which you may need to provide the other parent for reimbursement.

There is a $25.00 charge for returned checks.

In the event your account becomes delinquent, you will be responsible for collection fees, attorney fees and court costs.

For your convenience we accept: Cash, Check, Debit Cards, Credit Cards and Various Dental Credit Payment Programs*.
(*Ask our staff for details)

Broken Appointment Policy
Lowry Dental LLP requires 24-hours notice for cancellation or rescheduling of an appointment. If 24 hours is not given, a $25.00 broken appointment fee may be charged.

I agree to the above Financial Policy and Office Policies:

______________________ ______________________

Patient, Parent or Legal Guardian Date