LOWRANCE DENTAL

REGISTRATION FORMS

(Please print)

Today's Date:	Primary Care Physician & Phone #:			
PATIENT INFORMATION				
Patient's Last Name: First: Middle:			☐ Mr. ☐ Mrs. ☐ Miss	Marital Status: ☐ Single ☐ Married ☐ Div ☐ Other
Is this your legal name?	If not, what is your legal name:	Sex:	Age:	Birth date:
Street Address:	City:	State:	Zip:	
P.O. BOX:	Social Security:	Home/Cell #:		
Email:	Occupation:			
Employer:	Employer phone #:			
How did you hear about our office? Dr. _____ Insurance Plan Hospital: _____ Family Friend: _____ Location Online Other: _____				
Other family members seen here:				
Preferred Pharmacy:	Phone Number:			
DENTAL INSURANCE INFORMATION				
Person responsible for bill:	Birth Date:			
(Please give your insurance card to the front desk)				
Address (if different):				
Phone # (if different):	Is this person a patient here?			
Please circle **dental** insurance: Aetna Assurant BCBS Cigna Concordia Delta Dental of Delta Health Alli. GEHA United Heath Other:				
Subscriber's Name:	S.S #:	Birth date:		
ID Number:	Group #:			
Occupation:	Employer:			
Employer address:	Employer phone #:			
Secondary Insurance:	ID #:			
EMERGENCY CONTACT				
Name:	Relation:	Phone #:		

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Lowrance Dental or insurance company to release any information to process my claims.

_____ _____

Patient/Guardian signature *Date*

LOWRANCE DENTAL

MEDICAL AND DENTAL HEALTH HISTORY FORM

MEDICAL HISTORY

CIRCLE THE APPROPRIATE ANSWER

1. Are you currently under a physician's care? ..... Y N
   *If so, why?*_____
2. When was your last complete physical exam?_____
3. Are you required to take a Pre-Med before treatment? ..... Y N
4. Are you taking any medications or health related substances? ..... Y N
   If so, please list:
   *What?*_____ *Why?*_____
   *What?*_____ *Why?*_____
   *What?*_____ *Why?*_____
   *What?*_____ *Why?*_____
   *What?*_____ *Why?*_____
   *What?*_____ *Why?*_____
   *What?*_____ *Why?*_____
5. Are you allergic to any medications or substances? ..... Y N
   If so, what? _____
6. Do you have asthma or other respiratory difficulties? ..... Y N
7. Have you ever had rheumatic fever? ..... Y N
8. Do you have high blood pressure? ..... Y N
9. Are you aware of any heart murmurs? ..... Y N
10. Do you have a pacemaker or an artificial heart valve? ..... Y N
11. Do you have any other heart disease or condition? ..... Y N
12. Do you have do you have any disorders such as anemia, leukemia, etc? .. Y N
13. Have you ever bled excessively after being cut or injured? ..... Y N
14. Do you have arthritis or rheumatism? ..... Y N
15. Do you have any artificial joints, implants or prosthesis? ..... Y N
16. Have you ever had radiation treatment to your head or neck? ..... Y N
17. Do you have any stomach problems? ..... Y N
18. Do you have any kidney problems? ..... Y N
19. Do you have any liver problems? ..... Y N
20. Are you diabetic? ..... Y N
21. Do you have epilepsy or seizure disorder? ..... Y N
22. Do you have or have had venereal disease? ..... Y N
    If so, what and when? _____
23. Have you ever tested HIV positive? ..... Y N
24. Do you have AIDS? ..... Y N
25. Have you had or do you test positive for hepatitis? ..... Y N
26. Do you or have you had TB? ..... Y N
27. Have you ever had a serious illness or major surgery? ..... Y N
    If so, explain _____
28. Do you smoke or use any other form of tobacco? ..... Y N
    If so, what and how much? _____

FOR OFFICE USE ONLY

DATE _____ BP _____
DATE _____ BP _____
DATE _____ BP _____
DATE _____ BP _____

NOTES:

29. Have you been or are you addicted to alcohol or drugs? ..... Y N
    *If so, what?*_____
30. Have you had psychiatric treatment? ..... Y N
31. Is there anything else we should know about your health? ..... Y N
    If so, explain _____
32. Would you like to talk to the Doctor privately about any problem? ..... Y N
33. Have you been COVID vaccinated? ..... Y N
34. If so, circle one: Pfizer Moderna J&J

<u>Women:</u>

1. Are you pregnant or planning to become pregnant? ..... Y N
2. Do you use birth control medication? ..... Y N

DENTAL HISTORY

1. Do you think you have a healthy mouth? ..... Y N
2. Are you happy with the appearance of your smile? ..... Y N
3. Who was your previous dentist and why did you leave that office?
   _____
4. Do you have any concerns about having dentistry done? ..... Y N
   If so, explain _____
5. Have you had problems or complications with previous
   dental treatment?? ..... Y N
   *If so, explain*_____
6. How long since your last dental visit? _____
7. When were your teeth last cleaned? _____
8. Are you aware of any problems in your mouth? ..... Y N
9. Do you clench or grind your teeth? ..... Y N
10. Does your jaw lock or pop? ..... Y N
11. Do you have pain in the muscles of your face or around your ears? ..... Y N
12. Have you ever had your bite adjusted? ..... Y N
13. Has a bite guard ever been recommended for you? ..... Y N
    If so, do you use a bite guard now? ..... Y N
14. Do you have a problem area where food catches between your teeth? ... Y N
    If so, where does this occur _____
15. Have you ever had gum treatment or surgery? ..... Y N
    What? _____
    When? _____
    Where? _____
16. Do you have sensitive teeth? ..... Y N
17. Do your gums bleed or hurt? ..... Y N
18. Do you notice any mouth odors or bad tastes? ..... Y N
19. Do you frequently get cold sores, blisters, or any other oral lesions? ..... Y N
20. Have you noticed any loose teeth or change in your bite? ..... Y N
21. Is there anything else you would like our dental office to know? ..... Y N
    *If so, please explain*_____

FOR OFFICE USE ONLY

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Patient Signature: _____ Date: _____

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study modes, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetics agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I agree to be responsible for payments of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the vent payments are not received by agrees upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient/Guardian Signature: _____ *Date*: _____

Financial Arrangement Available For Our Patients

Payment is due when dental services are rendered unless other arrangements have been made in advance.

If we are filing primary dental insurance for your visit, we ask you to cover 50% of services rendered. If we have a pre-treatment estimate on file for your treatment, we would then ask you to cover only what insurance is not paying for.

On major treatment requiring more than one visit to complete that procedure fee (or patient portion if we are filing insurance) is expected when prosthetics ie: crowns, bridges, full and partial dentures, porcelain veneers are delivered.

If extended payments are needed, we have available a way for our patients to pay for dental work over a period of time. It is called Care Credit which enables our patients the option of 3, 6 or 12 months in which to pay for their dental treatment with no interest or for a period of up to 60 months with extended term financing. Our office manager has all the necessary information if interested.

We reserve the right to charge for appointments cancelled or broken without 24 hour notice.

I have read, understand and agree to the above financial policy.

Patient/Guardian Signature: _____ *Date*: _____

Lowrance Dental

Acknowledgement of Receipt
Consent to Use and Disclosure of Protected Health Information

Notice of Privacy Practices
Review our Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may choose to review the Notice prior to signing this consent. By signing below, you acknowledge that we have given you a copy of our Notice of Privacy Practices.

Use and Disclosure of your Protected Health Information
Your Protected Health Information will be used by our practice or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the use or disclosure of your Protected Health Information.
Our office may or may not agree to restrict the use or disclosure of your Protected Health Information.
If we agree to your request, the restriction will be binding with our office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of Federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your Protected Health Information. However, you must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

I give permission for the use and disclosure of my health information as set forth above.

Patient or Legally Authorized Individual Signature

Date Time

Print Patient's Full Name _____

Witness Signature

Date Time