LOWRY DENTISTRY

210 S. Willow Street • Gastonia, NC 28054

Today's Date

Welcome to our office! Please answer all questions as completely as possible. This information is confidential and is important for your treatment. If you have any questions regarding your treatment, appointments, or fees, please ask one of our staff.

Child Patient Information

Patient Name		Age	Gender - Circle One Male Female	DOB
Preferred Name		Home Phone	Cell Phone	
Address		Email Address		
City/State/Zip		SS#	School	
Emergency Contact		Relationship	Phone # (H)	(C)

Parent / Guardian Information

Mother's Name		Father's Name	
Address		Address	
Phone		Phone	
SS#		SS#	
Occupation	Employer	Occupation	Employer
Employer's Address		Employer's Address	

Insurance Information

Primary Insurance	Employer	Secondary Insurance	Employer
Policy #	Group #	Policy #	Group #
Insured Name		Insured Name	
Address		Address	
City/State/Zip		City/State/Zip	
Insured DOB	Insured SS#	Insured DOB	Insured SS#

How would you like to be contacted

Phone Text: Email:

Consent for Healthcare and Release of Medical Information

I voluntarily consent to treatment at this facility by its doctors and staff. No guarantees have been made to me about the results of treatments or examination by staff at this practice. I consent to the use and disclosure of my protected health information for treatment, payment and healthcare operations. I have read this form and had the opportunity to ask questions.

Financial Responsibility and Assignment of Insurance Benefits

I authorize Lowry Dentistry to bill my insurance company using the information I have provided to this office for payment to their facility. I assign payment for the unpaid charges for certain dental services to Lowry Dentistry. I understand I am responsible for any dental insurance deductible and co-insurance payments. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any medical or any other information about me to be released to the Social Security Administration or its intermediaries or carriers and any information needed for this or a related Medicaid claim. I request that payment of authorized benefits be made on my behalf.

Signature of Patient or Authorized Person: _____ Date: _____