Date _____

LOWRY DENTISTRY

210 S. Willow Street • Gastonia, NC 28054

Welcome to our office! Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication you may be taking could have an important interrelationship with the dentistry you will receive. Please answer all the questions as completely as possible. This information is confidential. If you have any questions please ask one of our staff

Patient Information

Patient Name *(First)* *(Middle)* *(Last)*	DOB	Gender - Circle One M F
Preferred Name	Home Phone	Cell Phone
Address	Email Address	
City/State/Zip	SS#	Marital Status - Circle One S M D W
Emergency Contact	Relationship	Phone # (H) (C)

Employer/Insurance Information

Company Name _____ Employer Name _____ Work # _____

Name of Insurance Co. _____ Ins. Co. Phone # _____

Name of Policy Holder _____ DOB _____ SS# _____

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.

Signature of Patient or Authorized Person: _____ Date: _____

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: _____