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.

Patient Information

Patient Name		Age	Gender - Circle One **Male Female**	DOB
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)	

Employment Information

Employer	Contact Name	Work Number
Address	City/State/Zip	

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#

Additional Information

Parent/Guardian Name	Day Phone

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: ________

_____ ***Premedicate*** (for office use only) Date ________________

Medical and Dental History

Please print clearly Y for yes and N for no.

_____ Are you in good health?
_____ Under a physician's care?
_____ if yes, please indicate why
_____ Have you been hospitalized or had a serious illness?

If female,
_____ Are you pregnant?
_____ If yes, please indicate how far along and if you are having any complications ______________________
____
_____ Do you smoke? ______________________

_____ Regular dental care?
_____ Do you have hot/cold sensitivity?
_____ Frequent headaches?
_____ Do your gums bleed with brushing/flossing?
_____ Do you have unusual or frequent pain in
_____ teeth _____ jaw joints
_____ jaws _____ ears
_____ Do you have any unusual swelling in your mouth?
_____ Are you frightened of dental treatment?
Reason for coming: ____________________
Who referred? ____________________

Name of family Physician ________________________________ Date of last physical __________
Previous Dentist ________________________________ Date of last dental exam ________

Do you have/had any of the following?

- Take Bisphosphonates (Calcium Metabolism Modifiers) ☐
- AIDS/HIV ☐
- Blood transfusions ☐
- Joint replacements ☐
- Heart valve replacements ☐
- Diagnosed with cancer ☐
- if yes, what kind ______________
- Radiation treatment or chemotherapy ☐
- if yes, when was your last treatment ______________
- Bruise easily or trouble clotting ☐
- ex. Boniva, Fosamax, Actonel, Reclast, Zometa

- Allergies ☐
- Latex Allegies ☐
- Anemia ☐
- Arrhythmia ☐
- Hepatitis ☐
- Asthma/Hay fever ☐
- Diabetes ☐
- Epilepsy ☐
- Glaucoma ☐
- Heart murmur ☐
- High blood pressure ☐
- Sickle cell anemia ☐

- Kidney/Liver problems ☐
- Mitral Valve Prolapse ☐
- Rheumatic Fever (childhood) ☐
- Tuberculosis ☐
- Venereal Disease ☐
- Night Sweats ☐
- Persistent cough ☐
- Fatigue ☐
- Weight loss ☐
- History of Drug Dependency ☐
- Other ______________ ☐

Please list all medications you are presently **taking**: ________________________________
____
____

Please list all allergies (ex. medications, latex): ________________________________
____
____

I understand that the doctor is not responsible for completion of treatment if I fail to make scheduled appointments. I hereby certify that I have read the above information and that is accurate to the best of my knowledge. The above information is confidential and will be used for my dental treatment. I understand that not providing accurate information could be detrimental to my health

____ ______________
(Signature of patient or legal guardian) (Date)

UPDATE MED HX: (for office use only)

Date	**Changes**