Lowry Family Dental 2512 East Market St. Warren, Ohio 44483 330-394-6660

Patient Registration

First Name: _____ M/I: _____ Last Name: _____

DOB: _____ Age: _____ SSN: _____ Sex: Male Female

Marital Status (circle one): Single Married

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____

Employer: _____ Retired: Yes No

How did you hear about us? _____

Are you the responsible party for this account? Yes No (if no, who is?) _____

Insurance Information

Name of Insured: _____ Relationship to patient: _____

Insured's SSN: _____ Insured's DOB: _____

Employer: _____ Retired: Yes No

Secondary Insurance Information (if applicable):

Name of Insured: _____ Relationship to patient: _____

Insured's SSN: _____ Insured's DOB: _____

Employer: _____ Retired: Yes No

Financial Responsibility and Treatment Consent

I give my consent to any advisable and necessary dental procedures, medications or anesthetics to be administered by the attending dentist or by the supervised staff for diagnostic purposes or dental treatment. I understand and acknowledge that I am financially responsible for the services provided for myself or the below named, regardless of insurance coverage.

I authorize my doctor to act as my agent in helping me obtain payment from my insurance company.

_____ Date: _____

(Signature of patient, guardian or personal representative)

_____ Relationship to patient: _____

(Printed name of patient, guardian or personal representative)

Patient Medical History

Primary Care Physician: _____ Date of Last Exam: _____

Are you under medical treatment now? Yes No If yes, for what? _____

Have you ever been hospitalized for any surgical operation/serious illness? Yes No

Please check if you are taking these kinds of medication: __Blood Thinners __Bisphosphonates (Osteoporosis)

Please list any medication(s) including non-prescription medicine you are currently taking:

_____

Have you had any recent chemo or radiation therapy? Yes No Do you use tobacco? Yes No

Please check if you are allergic to or have had reactions to any of the following:

__Local Anesthetics __Barbiturates __Iodine __Sulfa Drugs __Sedatives __Penicillin or other antibiotics

Do you have a persistent cough/throat clearing not associated with a known illness? Yes No

Please check if you have or have had any of the following:

__AIDS/HIV __Heart Disease __Chest Pains __High Blood Pressure __Heart Attack __Easily Winded __Rheumatic Fever

__Stroke __Angina __Swollen Ankles __Hay Fever/Allergies __Fainting/Seizures __Frequently Tired __Asthma __Tuberculosis __Anemia

__Radiation Therapy __Heart Murmur __Emphysema __Glaucoma __Epilepsy __Cancer __Recent Weight Loss __Leukemia __Arthritis

__Liver Disease __Diabetes __Heart Trouble __STD __Kidney Diseases __Pacemaker __Thyroid Problem __Respiratory Issues

__Hepatitis/Jaundice __Stomach Issues/Ulcers __Joint Replacement/Impant __Low Blood Pressure

Women Only: Are you/maybe pregnant? Yes No Are you nursing? Yes No Are you taking birth control? Yes No

Patient Dental History

Do your gums bleed while brushing or flossing? Yes No

Are your teeth sensitive to hold or cold liquids/foods? Yes No

Do you feel pain in any of your teeth? Yes No

Do you have any sores or lumps in or near your mouth? Yes No

Have you had any head, neck or jaw injuries? Yes No

Have you experienced any of the following problems in your jaw? Please Check:

___Clicking ___Pain ___Difficulty Opening/Closing/Chewing

Do you have frequent headaches? Yes No

Do you clench/grind your teeth? Yes No

Do you bite your lips/cheeks frequently? Yes No

Have you had any difficult extractions in the past? Yes No

Have you ever had prolonged bleeding following extractions? Yes No

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature: _____ Date: _____

Printed Name of Patient: _____ DOB: _____

Acknowledgment of Receipt of HIPAA Notice of Privacy Practices

Lowry Family Dental

2512 East Market St.

Warren, Ohio 44483

I, _____, hereby acknowledge that I have received and reviewed a copy of Lowry Family Dental's HIPAA Notice of Privacy Practices.

I understand that Lowry Family Dental's HIPAA Notice of Privacy Practices may change periodically and that I am entitled to receive a copy of Lowry Family Dental's revised HIPAA Notice of Privacy Practices upon request.

I understand that if I have questions about Lowry Family Dental's HIPAA Notice of Privacy Practices, I may contact Danny Lowry at 330-394-6660.

I understand that it is my right to refuse to sign this acknowledgment should I so choose, and that Lowry Family Dental will not refuse treatment to me if I refuse to sign this acknowledgment.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding Lowry Family Dental's privacy policies and procedures.

_____ Date: _____

(Patient Signature)

_____ _____

(Signature of Personal Representative) (Printed Name of Personal Representative)

_____

(Relationship of Personal Representative to Patient)