



200 Quebec St. Unit 105 • Denver, CO 80230
303-364-6659

Patient Information

Name: _____
Last First Middle
E-Mail Address: _____ Gender: Male _____ Female _____
Cell Phone: (____) _____ Home Phone: (____) _____ Work Phone: (____) _____
Home Address: _____
Street City State Zip
Date of Birth: ____/____/____ Social Security Number: ____-____-____ Driver's License or ID Number: _____
MM / DD / YYYY

Responsible Party Information (If Patient is a Dependent)

Name: _____
Last First Middle
Relationship to Patient: _____ E-Mail Address: _____
Cell Phone: (____) _____ Home Phone: (____) _____ Work Phone: (____) _____
Home Address: _____
Street City State Zip
Date of Birth: ____/____/____ Social Security Number: ____-____-____ Driver's License or ID Number: _____
MM / DD / YYYY

Dental Insurance Information (Please Provide a Copy of Your Card)

Name of Primary Policy Holder: _____
Last First Middle
Primary Policy Holder's Date of Birth: ____/____/____ Primary Policy Holder's SS/ Member ID Number: ____-____-____
MM / DD / YYYY
Primary Policy Holder's Employer: _____
Insurance Company Name: _____ Group Number: _____ Insurance Company Phone: (____) _____
Insurance Company Address: _____
Street City State Zip

Emergency Contact Information

Local Friend or Relative not Living With You: _____ Emergency Contact Phone: (____) _____
Emergency Contact Address: _____
Street City State Zip

Getting to Know You

Why did you select our office? _____ Whom May we thank for referring you? _____
Is another member of your family already a patient with our practice? Yes No Family Member? _____
When was your last dental visit? _____
When was the last time you had complete dental x-rays taken? _____ Have you ever had any teeth removed? _____
How long have these teeth been missing? _____
How Have these teeth been replaced? Bridge Partial Denture Implants They have not been replaced

FOR ALL PATIENTS

I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the dental care of the patient above, and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that prior to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office.

SIGNATURE OF RESPONSIBLE PARTY

RELATIONSHIP TO PATIENT

DATE

MEDICAL HISTORY – Please Answer ALL Questions

Name: _____ Date of Birth: _____ Age: _____

Gender: Male / Female Height: _____ ft. _____ in. Weight: _____ lbs.

Primary Care Physician: _____ Phone/Contact: _____

- 1. Do you consider yourself a healthy person? Yes No
- 2. Have you been under the care of a medical doctor during the past two years? Yes No
If yes, for what reason? _____ Est. Last Physical Exam Date: _____
- 3. Do you consider your teeth, gums and mouth to be healthy and problem free? Yes No
- 4. Do your gums bleed at any time? Yes No
- 5. Are you allergic to (i.e., itching, rash, swelling or hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications? Yes No
If yes, please list. _____
- 6. Have you ever had excessive bleeding requiring special treatment? Yes No
- 7. Women: Are you or might you be pregnant? Yes No Estimated Due Date _____

8. Check any and all of the following which you have a history of or currently under treatment for:
- | | | |
|--|---|---|
| <input type="checkbox"/> Heart Disease or Attack | <input type="checkbox"/> Ulcers | <input type="checkbox"/> HIV Positive (AIDS) |
| <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Cancer or Tumor |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis (circle: Type A, B or C) | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Heart Murmur/Mitral Valve |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bruise Easily |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Chemotherapy (Cancer, Leukemia) | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cold Sores or Fever Blisters |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Cortisone Medication | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Psychiatric Treatment |

Do you have or have history of any surgery, disease or medical condition not listed on this form? Yes No

Please list: _____

9. List all Prescription Medications you are taking at this time. None _____

- 10. Do you use any type of tobacco product regularly? Yes No
- 11. Do you use or have you ever used recreational drugs? Yes No
- 12. Do you clench or grind your teeth? Yes No
- 13. Do you or have you been told you snore loudly (enough to bother others)? Yes No
- 14. Are you aware or have you been told you stop breathing or are choking while sleeping? Yes No
- 15. Do you often feel tired, fatigued or can't stay awake during the daytime? Yes No
- 16. Do you currently use or have been diagnosed to need a CPAP breathing machine to sleep? Yes No

Signature: _____ Date: _____

Updates (date & initial) _____

Our goal is to make your experience in our office exactly how you want it to be. Please take a few moments and complete this profile so we can be of service to you as comfortable as possible.

1. Please rate the following statements regarding what is most important to you in dental care so we can best serve you: (#1 being the most important)

___ Long-Term Preventative Care...I have healthy teeth and want to keep them that way.

___ Creating a Comprehensive Overall Dental Care Plan...I want to Invest in my Teeth and Appearance

___ Dental Care is budget driven. I will have to plan financially for any treatment beyond my immediate needs.

___ Other Goals: _____

2. Please circle how important is it for you to keep your teeth for a lifetime? (10 being very important)

1 2 3 4 5 6 7 8 9 10

3. Are you concerned about: (please circle yes or no)

Replacing missing teeth Yes No Straightness of your teeth or bite Yes No

Eliminating any cavities Yes No Snoring at night Yes No

Gum disease Yes No Color of your teeth Yes No

Bad breath Yes No Appearance of your smile Yes No

4. Are you or anyone in your family interested in a **complimentary** orthodontic (Braces or Invisalign) consultation with our Orthodontist? Yes No

We know dental care can be very stressful for most people. Please share your concerns and past experiences to help guide us in serving you and your family more effectively.

5. Please circle the level of fear you have regarding dental treatment for yourself. (10 being the most fearful, 1 being the least amount of fear)

1 2 3 4 5 6 7 8 9 10

6. When we review your treatment plan with you, would you like to know (please check one):

___ I am a big picture type person, I prefer to review the plan looking at all the things that need to be done.

___ I am a detail oriented person, I prefer to approach each treatment step along the way

7. Please briefly describe any bad dental experiences you have had: _____

THANK YOU

DENTAL INSURANCE POLICY

Lowry Family Dental proudly accepts most dental insurance plans. We file all dental insurance claims as a patient courtesy. In the event of a treatment plan, we create a reasonable estimate of patient co-payments and insurance contributions. This estimate is based on contracted insurance rates, the general breakdown of benefits obtained through the insurance verification process and our knowledge of common insurance exclusions. **This estimate is not a guarantee of insurance payment. All benefit determinations are at the discretion of the insurance company and are not determined until after a claim is submitted.** We provide treatment estimates as a courtesy in order to minimize the total out-of-pocket cost due by patient. **All estimated patient co-payments are due on or before time of service.**

Patient is responsible for any remaining account balance resulting from insurance nonpayment or underpayment. A statement will be mailed to you regarding this balance. Payment is due immediately upon receipt.

-----PATIENT ACKNOWLEDGMENT AND AUTHORIZATION-----

I understand and agree to the Dental Insurance Policy stated above. I authorize all my insurance companies to make payment directly to Lowry Family Dental. This assignment will remain in effect unless revoked by me in writing. I understand I am financially responsible for all charges whether or not paid by said insurance company. Further, I authorize the release of any patient information necessary to process these claims.

Signature: _____ Date: _____

APPOINTMENT DEPOSIT REQUIREMENT

Lowry Family Dental requires a minimum \$50.00 deposit for all appointments requiring 90 minutes or more of estimated chair-time and for all appointments with a total treatment cost of \$500.00 or more. The deposit operates as a credit on the patient account towards the total patient portion due on or before time of service. Lowry Family Dental requires this deposit because our providers and dental assistants reserve the appointment time specifically for you at the exclusion of other patients. **The deposit requirement is subject to our Cancellation Policy.**

The deposit requirement is reserved only for those patients choosing not to pre-pay for their services in full when scheduling the appointment.

I understand and agree.

Signature: _____ Date: _____

CANCELLATION POLICY

Lowry Family Dental makes an effort to see patients on time in order to give patients the care they deserve. Therefore, we ask that you **please give 48 hours notice if you are unable to keep your scheduled appointment. We reserve the right to charge a cancellation fee of \$50.00 in the event of two (2) or more missed appointments lacking proper notice.** We will make exceptions in the event of reasonable emergencies.

I understand and agree.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICES

I, _____, have had the opportunity to review Lowry Family Dentals Notice of Privacy Practices (the entire legal notice is displayed at the front desk).

Signature: _____ Date: _____