

Dr. Lowery's Dental Group

425 S. Cherry St., Suite 210
Denver, CO 80246
303.753.0922

NEW PATIENT AGREEMENT

Thank you for trusting our office with your dental care. In order to maintain the high rapport and cooperation between the doctor and the patient necessary for a mutually satisfactory completion of the patient's dental care, we ask that you agree to the following:

I acknowledge that my appointments are times reserved specifically for me. I agree that if I can't make an appointment, I will call Dr. Lowery's office at least 24 hours in advance so they can fill that time with another patient's appointment. If I give Dr. Lowery's office less than 24 hours notice, I agree to pay a \$50 cancellation fee.

(In recognition of your effort to keep your appointments, Dr. Lowery and her staff agree to respect your time and will keep your appointment to the time scheduled.)

I understand that I am responsible to pay for services rendered, co-pays or non-covered benefits at the time of service. I understand that any outstanding balance due more than 60 days will incur finance charges at 1.39%. I am responsible for attorney's fees and costs of collection efforts if I do not pay my obligations for service to Teresa M. Lowery, DDS PC.

(Dr. Lowery and her staff agree to make every effort to verify insurance and benefits. We also guarantee that you will be presented with a treatment plan for you to agree to prior to doing any procedure other than routine.)

Signature of patient: _____

Dr. Lowery's signature: _____

Date: _____

PRESCRIPTION DRUG MONITORING NOTIFICATION

By signing this form, you confirm that you have been notified that if you receive a prescription for a controlled substance (narcotic drug) from our office and fill that prescription at a pharmacy in Colorado, certain identifying prescription information, including the name of the patient, will be entered into a secure database maintained by Colorado's prescription drug monitoring program. State law requires pharmacies to report information about controlled substance prescriptions filled to the prescription drug monitoring database.

This database is used to help prevent inappropriate uses of controlled substances – like fraud and diversion. The prescription drug monitoring program database contains only records related to controlled substances (narcotic drugs like painkillers, muscle relaxants and steroids). It does not contain records about other prescription drugs like antibiotics, antidepressants or any other category of prescription medication.

Only authorized individuals, like healthcare personnel that prescribe controlled substances and law enforcement under very limited circumstances, can access the database and only for tightly defined uses. As long as you are using controlled drugs appropriately, there shouldn't be reason for concern. If you do not want your information in the database, please ask your dentist to prescribe non-narcotic drug for you.

More information about Colorado's prescription drug monitoring program, including copies of individual prescription drug records stored in the database, can be obtained from the Colorado state Department of Regulatory Agencies by calling 303-894-5957 or by visiting <http://www.dora.state.co.us/pharmacy/pdmp/consumers.htm> .

I have read and understand this notification.

Date

(Signature of patient/guardian)

If this notification is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:

Relationship to Patient:

Teresa M. Lowery, D.D.S., P.C. – Notice of Privacy Practices

This Notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us here in our office.

Our legal duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect on April 14, 2003, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact the Practice Administrator listed at the end of this disclosure.

Uses and Disclosures of health information

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use or disclose your health information to obtain payment for services we provide to you. In order for us to electronically submit any claims on your behalf to your insurance company, we must have your written permission. By signing here, you give us this permission.

Date: _____

Healthcare Operations: We may use or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. However nothing in this section requires non-licensed individuals to oversee, supervise or dictate the professional activities of duly licensed dental professionals.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help you with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are the possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities, the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials, health information required for lawful intelligence,

counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment reminders: We may use or disclose your health information to provide you with appointment reminders (such as voice mail messages, e-mail, postcards or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your healthcare information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$1 for each page, \$50 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge you a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or locations, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS:

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may express such concerns to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Mary Staples
Telephone: 303-753-0922
Address: 425 S. Cherry St., Suite 210, Denver, CO 80246

PATIENT INFORMATION

PATIENT'S NAME Last _____ First _____ Middle Initial _____ SEX: M F BIRTHDATE _____ AGE _____
 Soc. Sec. # _____ If Patient is a Minor, give Parent's or Guardian's Name _____ TODAY'S DATE _____
 Who May We Thank for Referring You to our Office? _____ Reason for this Visit _____

RESPONSIBLE PARTY INFORMATION

NAME Last _____ First _____ Middle Initial _____ MARITAL STATUS _____
 RESIDENCE Street _____ Apt. # _____ City _____ State _____ Zip _____
 MAILING ADDRESS Street _____ Apt. # _____ City _____ State _____ Zip _____
 HOW LONG AT THIS ADDRESS _____ HOME PHONE _____ CELL PHONE _____
 WORK PHONE _____ E-MAIL _____
 PREVIOUS ADDRESS (if less than 3 yrs.) Street _____ City _____ State _____ Zip _____ How Long _____
 SOCIAL SECURITY # _____ BIRTHDATE _____ DRIVER'S LICENSE # _____ RELATION TO PATIENT _____
 EMPLOYER _____ OCCUPATION _____ NO. YEARS EMPLOYED _____

RESPONSIBLE PARTY'S SPOUSE

NAME _____
LAST FIRST MIDDLE
 EMPLOYER _____ OCCUPATION _____ ()
SOC. SEC. # BIRTHDATE NO. YEARS EMPLOYED
 HOME PH. _____ CELL PH. _____
 WORK PH. _____ E-MAIL _____

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME _____ RELATIONSHIP _____
 ADDRESS _____ CITY, STATE _____
 HOME PH. _____ CELL PH. _____
 WORK PH. _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____
 Insurance Co. _____ E-MAIL _____
 Insurance Co. Address _____
 Insured's Employer _____
 Insured's Soc. Sec. # _____ Group # _____ Local # _____

If you have double dental insurance coverage, complete this for the second coverage.

Insured's Name _____
 Insurance Co. _____ E-MAIL _____
 Insurance Co. Address _____
 Insured's Employer _____
 Insured's Soc. Sec. # _____ Group # _____ Local # _____

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

DENTAL HISTORY		YES	NO	*MEDICAL HISTORY*				YES	NO			
HOW LONG SINCE you have seen a dentist?				Do you have any CURRENT HEALTH PROBLEMS?				<input type="checkbox"/>	<input type="checkbox"/>			
Last COMPLETE Dental Exam, Date:				Are you under a PHYSICIAN'S CARE now?				<input type="checkbox"/>	<input type="checkbox"/>			
Last FULL MOUTH X-RAYS, DATE:(16 Small Films or Panoramic)				For what?								
Are you having PROBLEMS now?		<input type="checkbox"/>	<input type="checkbox"/>	What MEDICATIONS are you currently taking?								
WHAT?												
Is your present dental health POOR?		<input type="checkbox"/>	<input type="checkbox"/>	Have you ever taken Fen-Phen/Redux?				<input type="checkbox"/>	<input type="checkbox"/>			
Do you wear DENTURES? (Partials or Full)		<input type="checkbox"/>	<input type="checkbox"/>	Are you PREGNANT?				<input type="checkbox"/>	<input type="checkbox"/>			
Are you UNHAPPY with your dentures?		<input type="checkbox"/>	<input type="checkbox"/>	Do you use cigars/cigarettes, pipe or chewing tobacco? (circle)				<input type="checkbox"/>	<input type="checkbox"/>			
Would you like to know more about PERMANENT REPLACEMENTS?		<input type="checkbox"/>	<input type="checkbox"/>	PLEASE ✓ YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:								
Are you APPREHENSIVE about dental treatment?		<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV Pos.	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric care	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any PERIODONTAL (GUM) treatments?		<input type="checkbox"/>	<input type="checkbox"/>	Anaphylaxis	<input type="checkbox"/>	<input type="checkbox"/>	Food allergies	<input type="checkbox"/>	<input type="checkbox"/>	Rapid weight gain/loss	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums BLEED, or feel TENDER or IRRITATED?		<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Radiation treatment	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)		<input type="checkbox"/>	<input type="checkbox"/>	Arthritis (Rheumatism)	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory disease	<input type="checkbox"/>	<input type="checkbox"/>
Are you UNHAPPY with the APPEARANCE of your teeth?		<input type="checkbox"/>	<input type="checkbox"/>	Artificial heart valves	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic/scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>
Are you aware of GRINDING or CLENCHING your teeth?		<input type="checkbox"/>	<input type="checkbox"/>	Artificial joints	<input type="checkbox"/>	<input type="checkbox"/>	Heart problems (please describe)	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>
Do you have HEADACHES, EARACHES, or NECK PAINS?		<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Have you worn BRACES on your teeth (ORTHODONTICS)		<input type="checkbox"/>	<input type="checkbox"/>	Atopic (Allergy Prone)	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia (Abnormal bleeding)	<input type="checkbox"/>	<input type="checkbox"/>	Skin rash	<input type="checkbox"/>	<input type="checkbox"/>
Do you have DISCOLORED teeth that bother you?		<input type="checkbox"/>	<input type="checkbox"/>	Back problems	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Spina Bifida	<input type="checkbox"/>	<input type="checkbox"/>
Would you like your smile to LOOK BETTER or DIFFERENT?		<input type="checkbox"/>	<input type="checkbox"/>	Blood disease	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Do you REGULARLY use DENTAL FLOSS?		<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Surgical implant	<input type="checkbox"/>	<input type="checkbox"/>
Name of Previous Dentist:				Chemical dependency	<input type="checkbox"/>	<input type="checkbox"/>	Jaw pain	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of feet or ankles	<input type="checkbox"/>	<input type="checkbox"/>
City: _____ State: _____				Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease or malfunction	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease or malfunction	<input type="checkbox"/>	<input type="checkbox"/>
How do you feel about your teeth?				Circulatory problems	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco habit	<input type="checkbox"/>	<input type="checkbox"/>
Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment.				Cortisone treatments	<input type="checkbox"/>	<input type="checkbox"/>	Material allergies	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
FEAR of pain # _____ LACK of concern # _____				Cough (persistent)	<input type="checkbox"/>	<input type="checkbox"/>	(latex, wool, metal, chemicals)	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
COST of treatment # _____ MISSING work time # _____				Cough up blood	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer/Colitis	<input type="checkbox"/>	<input type="checkbox"/>
				Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Nervous problems	<input type="checkbox"/>	<input type="checkbox"/>	Veneral disease	<input type="checkbox"/>	<input type="checkbox"/>
				Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker/heart surgery	<input type="checkbox"/>	<input type="checkbox"/>			
				ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?								
				Aspirin	Local Anesthetic	Erythromycin	Latex (balloons, gloves, etc.)					
				Nitrous Oxide	Codeine	Penicillin						
				Are you aware of being allergic to any other medications or substances?								
				If yes, please list:								
				Is there any other Medical or Dental information that you feel I should know about?								
				FAMILY PHYSICIAN _____ PHONE _____ E-MAIL _____								

PATIENT Signature (Parent of Child) _____

Date: _____

DENTIST Signature _____