LOWE
DENTAL CARE
COSMETIC, IMPLANT & COMPLETE FAMILY DENTISTRY
WHERE EXPERIENCE MEETS TECHNOLOGY
Carole S. Lowe-Richens, D.D.S.
1552 W. Warm Springs Road, Ste. 120 - Henderson, NV 89014
Phone: (702) 451-1889 - Fax: (702) 451-6067
E-mail: Carole@LoweDentalCare.com - Website: www.LoweDentalCare.com

NEW PATIENT FORMS

INSTRUCTIONS:

1. Print our **New Patient** forms (8 pages).

2. Read the **Instructions** (Page 1).
   Keep this notice for your records.

3. Complete the **Information Form** (Page 2 and 3).
   - Health Information
   - Patient Information
   - Employment Information
   - Spouse of Responsible Party Information
   - Insurance Information
   - Referral Information
   - Appointment Policy
   - Insurance Authorization
   - Financial Policy

   Bring this form to our dental office for your initial visit.

4. Read the **Notice of Privacy Practices** (Page 4, 5, and 6).
   Keep this notice for your records.

5. Complete, sign and date the **Acknowledgement of Receipt of Notice of Privacy Practices** (Page 7). Bring this form to our dental office for your initial visit.

6. Read and complete the **Financial Responsibility Acknowledgement** (Page 8).
   Bring this form to our dental office for your initial visit.

Health Information

NAME: _____ DOB: _____ SS#:_____
Last First MI

Date of Last Dental Visit: _____ Reason for visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV+
- ☐ Allergies_____ _____
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Chronic Cough
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disease
- ☐ Developmental Disability
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Bleeding
  - Bruise Easily _____
  - Blood Thinners ____
  - Hemophilia _____
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease/Attack
- ☐ Heart Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Surgery_____
- ☐ Hepatitis_____
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease/Trouble
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Nervousness
- ☐ Pregnancy
  Due Date_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHERS:

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

FOR OFFICE USE

B.P. _____

PULSE: _____

Please list any medications you are currently taking: _____

_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been, in the past two years, or are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of the Physician: _____Phone: _____
- Have you taken any medication or drugs in the past two years? _____
  If yes, please explain: _____
- Are you now taking any medication or drugs? _____
  If yes, please explain: _____
- Are you sensitive or allergic to any medication or anesthetics? _____
  If yes, please explain: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

_____Date:_____

CONSENT:

1. **The undersigned hereby authorizes the doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.**
2. **I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.**

Patient Signature: _____ Date: _____ Witness: _____

Parent or Responsible Party: _____ Relationship to the Patient: _____

FOR OFFICE USE ONLY: Reviewed by Dr. _____ Date: _____

Patient Information

Patient Name:_____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Social Security#:_____ Birth Date:_____ NVDL# _____

Phone (Home):_____ (Work):_____ Ext:_____ (Cell):_____ Best time to call: _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S

Address:_____
Street Apartment#

_____
City State Zip Code E-Mail address

How long in this address? _____

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name:_____ Occupation_____

Address:_____
Street City State Zip Code

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name:_____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Social Security#:_____ Birth Date:_____

Phone (Home):_____ (Work):_____ Ext:_____ Best time to call: _____

Address:_____
Street Apartment#

_____
City State Zip Code E-Mail address

Insurance Information

PRIMARY

Name of Insured: _____ is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date:_____ ID # _____ Group # _____

Insured's Address:_____
Street City State Zip Code

Insured's Employer Name:_____

Address:_____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan name and Address: _____

_____

SECONDARY

Name of Insured: _____ is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date:_____ ID # _____ Group # _____

Insured's Address:_____
Street City State Zip Code

Insured's Employer Name:_____

Address:_____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan name and Address: _____

_____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other

Name of the person or office referring you to our practice: _____

Appointment Policy

Every effort is made to keep on schedule so we respectfully ask patients to be on time and to keep their appointments. Our office policy is as follows: We call to remind patients of their appointments at least 24 hours in advance. **This time has been reserved especially for you**. If you need to reschedule your appointment, it is your responsibility to notify our office at least 24 hours prior to your appointment, so that we may make that time available to another patient. We do understand that unexpected issues can come up that can prevent patients from making their appointment. Under those circumstances we will reappoint to the next available appointment mutually agreed upon. Patients who do not give the required notice will become responsible for charges in full for their appointment.

_____ **Date:** _____

Signature of patient, parent or guardian

Relationship to Patient: _____

Insurance Authorization

We will gladly bill your insurance company as a courtesy to you. **All co-payments are estimates only** and are based on the previous payment history our office has had with your insurance company. Should your insurance company pay more than expected, a refund will be issued to you after all claims are received on your account. If we do not receive full insurance payment on your account, any balance is due and payable regardless of outstanding **estimated** insurance benefits. All insurance payments are authorized to be paid directly to the dentist. The patient or guardian is responsible for all dental services regardless of what the insurance pays. It is your responsibility to track benefit limitations and exclusions of your plan and coordination of benefits allowable if you have single or dual coverage.

_____ **Date:** _____

Signature of patient, parent or guardian

Relationship to Patient: _____

Financial Policy

As a condition for your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the cost incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for before the services are performed.

Patients who carry dental insurance(s) understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payments of all dental services. This office will prepare the patients insurance forms, assist in making collections from insurance companies, and will credit any such collections to the patients account. However, this dental office cannot render dental services on the assumption that **all** charges will be paid by an insurance company.

All estimated co-payments are estimates only, based upon the experience this office has with your insurance plan and can change at any time. If patients do not have dental insurance, full payment is expected at the time of service. I understand that I am responsible for all charges for myself and/or my dependents regardless of what my insurance company pays. I understand that any returned check will receive a **$35 NSF charge** and bad checks will be sent to the District Attorney's Office. If I fail to make payment, I understand that it will become necessary for my account to be referred to a collection agency. I understand that collection processing fees will be added. An **initial charge of $15.00 will be added to my account** that is referred to a collection agency. If the balance remains unpaid for another 45 days, collection processing fees in the amount of 50% of the remaining balance will also be added to my account to recover collections costs. All overdue accounts, unsuccessfully collected by the collection agency, will be referred to small claims court where court costs and fees will be added to my account possibly resulting in a judgment being placed on my record, my wages and/or bank accounts being garnished, or a lean placed on my real estate property.

_____ **Date:** _____

Signature of patient, parent or guardian

Relationship to Patient: _____

I grant my permission to your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ **Date:** _____

Signature of patient, parent or guardian

Relationship to Patient: _____

LOWE
DENTAL CARE
COSMETIC, IMPLANT & COMPLETE FAMILY DENTISTRY
WHERE EXPERIENCE MEETS TECHNOLOGY

Carole S. Lowe-Richens, D.D.S.
1552 W. Warm Springs Road, Ste120 – Henderson, NV 89014
Phone: (702) 451-1889 - Fax: (702) 451-6067
E-mail: Carole@LoweDentalCare.com - Website: www.LoweDentalCare.com

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.

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 (04/14/03), 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 changes in our privacy practices the new terms of our notice effective for all health information that we maintain, including health information we created or received before we make 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 us using the information listed at the end of this notice.

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.

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, licensing or credentialing activities.

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 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 location) 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 heath 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 a 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 institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may disclose the health information to provide you with appointment reminders (such as voicemail messages, postcard, 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 that you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. We will charge 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 $0.00 for each page, $0.00 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 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 the Notice for a full explanation of our fee structure.)

Disclosure Accounting: You may have the right to receive a list of instances in which your health information was disclosed for purposes other than treatment or 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.

Restriction: You may 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 may request that we communicate with you about your health information by alternative means or to alternative locations. We may agree to reasonable requests.

Amendment: You may 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.

Electronic Notice: If you receive this Notice in our Website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 complain 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:_____

Telephone:_____ Fax: _____

E-mail:
_____

Address:
_____

This form does not constitute legal advice and covers only federal law.

LOWE
DENTAL CARE
COSMETIC, IMPLANT & COMPLETE FAMILY DENTISTRY
WHERE EXPERIENCE MEETS TECHNOLOGY

Carole S. Lowe-Richens, D.D.S.
1552 W. Warm Springs Road, Ste. 120 - Henderson, NV 89014
Phone: (702) 451-1889 - Fax: (702) 451-6067
E-mail: Carole@LoweDentalCare.com - Website: www.LoweDentalCare.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Official Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

LOWE
DENTAL CARE
COSMETIC, IMPLANT & COMPLETE FAMILY DENTISTRY
WHERE EXPERIENCE MEETS TECHNOLOGY

Carole S. Lowe-Richens, D.D.S.
1552 W. Warm Springs Road, Ste. 120 – Henderson, NV 89014
Phone: (702) 451-1889 - Fax: (702) 451-6067
E-mail: Carole@LoweDentalCare.com - Website: www.LoweDentalCare.com

FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT

Thank you for choosing us as your dental care provider. The following is our financial policy. If you have any question about our payment policies, please do not hesitate to ask our friendly and courteous staff.

Payment for services is due at the time services are rendered. We accept cash, checks, and for your convenience, MasterCard, Visa, American Express and Discover. We also can pre-approve you for interest free credit through Care Credit. If your insurance coverage/company changes it is your responsibility to notify our office immediately.

You must understand the following:

1. Your insurance policy is a contract between you, your employer, and your insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company.

2. All services are provided to you with the understanding that you are responsible for their cost regardless of your insurance coverage. If you would like to know the cost of a service, please inquire with the staff prior to the services being rendered. Please be aware that **not** all services are covered benefits in all insurance policies and the expected payment from your insurance company is subject to change. You are responsible for knowing, per your insurance plan, what services are or are not covered. Fees for these services, along with any unpaid deductibles and co-payments are due at the time of treatment. You are responsible for these amounts. You are also responsible for any over maximum amounts.

3. We will bill the insurance information you provide to us as a courtesy to you, but you are still responsible for payment of any services you receive. We will also follow up on your claim by checking with your carrier once verbally and once in writing. If, however your insurance does not respond to us within 90 days of claim submission, the amount will become your responsibility and you will have to follow up with your carrier for payment of the claim.

We do understand that temporary financial situations may affect timely payment of your balance. We encourage you to communicate any such problems to us so that we can assist in the management of your account.

Signature of Responsible Party **Print Name** **Date**

LOWE
DENTAL CARE
COSMETIC, IMPLANT & COMPLETE FAMILY DENTISTRY
WHERE EXPERIENCE MEETS TECHNOLOGY

Carole S. Lowe-Richens, D.D.S.
1552 W. Warm Springs Road, Ste. 120 – Henderson, NV 89014
Phone: (702) 451-1889 - Fax: (702) 451-6067
E-mail: Carole@LoweDentalCare.com - Website: www.LoweDentalCare.com

ARE YOU INTERESTED IN A CLEANER, WHITER SMILE?

Only A Dentist Can Get Your Teeth Their Whitest!

ZOOM²! ONE HOUR TOOTH WHITENING
Professional Whitening System

The **ZOOM²** 1-hour chair side whitening system is a scientifically advanced, patent pending, tooth whitening procedure. The **ZOOM²** in-office whitening system will make your teeth dramatically whiter in less than an hour. The **ZOOM²** chair side whitening system is ideal for anyone looking for immediate results. It's safe, effective, and convenient. A perfect choice for the busy individual!

It begins with a short preparation to cover your lips and gums, leaving only your teeth exposed. The **ZOOM²** clinician then applies the proprietary **ZOOM²** whitening gel, which was designed to be used with a specially designed light. The **ZOOM²** light and gel work together to gently penetrate your teeth, breaking up stains and discoloration. With proper care, your smile will sparkle for years.

Dr. Carole Lowe-Richens also uses the **NITE WHITE** tooth whitening system from Discus Dental. **NITE WHITE** is a fast, safe, and effective tooth whitening system. The whitening gel is a thick solution that is dispensed to patients by their dentist, then applied by the patient at home using a clear and inconspicuous custom-fitted tray.

The delicious peppermint cream flavored gel is worn overnight, while you sleep, for ultimate performance and maximum convenience. In most cases, you can achieve exceptional whitening results in less than 10 days or nights.

The active ingredient in **NITE WHITE,** carbamide peroxide, has been recognized by FDA for many years as an oral antiseptic and is now used for its superior tooth whitening properties. **NITE WHITE** is available in a variety of carbamide peroxide concentrations to whiten even the most difficult stains.

Are you interested in hearing more about tooth whitening?

YES ☐ **NO** ☐

(Please Check One)

LOWE

DENTAL CARE

COSMETIC, IMPLANT & COMPLETE FAMILY DENTISTRY

WHERE EXPERIENCE MEETS TECHNOLOGY

Carole S. Lowe-Richens, D.D.S.

1552 W. Warm Springs Road, Ste. 120 - Henderson, NV 89014

Phone: (702) 451-1889 - Fax: (702) 451-6067

Email: Carole@LoweDentalCare.com - Website: www.LoweDentalCare.com

HEAD NECK & FACIAL PAIN DIAGNOSIS

PLEASE ANSWER THE FOLLOWING QUESTIONS, AS THEY ARE VERY IMPORTANT TO COMPLETING YOUR HEALTH HISTORY

Do you have any of the following symptoms? Please Print.	Please Circle	
1. Headaches	Yes	No
2. Dizziness	Yes	No
3. Lightheadedness	Yes	No
4. Neck aches or stiffness in the neck	Yes	No
5. Pain or Stiffness in the shoulders	Yes	No
6. Pain in the jaw joint	Yes	No
7. Pain in front of the ears	Yes	No
8. Pain in facial muscles	Yes	No
9. Sore throat	Yes	No
10. Arc you easily fatigued or tired at the end of the day	Yes	No
11. Forgetfulness or difficulty in learning new material	Yes	No
12. Ringing and buzzing or other sounds in the ears	Yes	No
13. Feeling of fullness in the cars or sinuses	Yes	No
14. Numbness or tingling or the fingertips	Yes	No
15. Backaches _____Upper _____Mid _____Lower	Yes	No
16. Clicking sounds from the jaw joint: _____Right _____Left _____	Yes	No
17. Popping sounds from the jaw joint: _____Right _____Left _____	Yes	No
18. Difficulty in opening the mouth fully	Yes	No
19. Difficulty in opening and closing the mouth	Yes	No
20. Pain in teeth: _____Upper _____Lower	Yes	No
21. Pain in, around, or behind the eyes	Yes	No
22. Visual Problems (eyesight getting worse)	Yes	No
23. Clench teeth during the day	Yes	No
24. Grind the teeth at night	Yes	No
25. Frequent stress encounters _____Home _____Work	Yes	No
26. Receive orthodontic treatment	Yes	No
27. Wisdom teeth been removed. When _____	Yes	No

Under what circumstances did the pain begin? _____

_____

What do you think is the cause of your pain? _____

_____

Are you currently taking any medication for these symptoms? If yes, please list._____

_____

NAME: _____ **DOB:** _____ **SS#:** _____

Last **First** **MI**

EARN A $25 AMERICAN EXPRESS GIFT CARD

Offer only valid when a friend or family member is referred.
Offer applies to new patient only.

Did you hear about Promotion?

We are giving away a free $25 gift card, YES FREE. We are giving away $25 gift card to show our appreciation for referring your family members, friends and co-workers…

We will be giving away a $25 American Express gift card for each new adult patient you refer that completes a new patient appointment. Please ask our friendly office staff about some of our other specials too.

$25 American Express gift card

New Patient must put your name on their paperwork as the referral

$25 American Express gift card is awarded after new patient's first visit