LOWMAN FAMILY DENTAL
PO Box 292
501 Empire Street
Holmen WI 54636-5000

(608)526-4707
contactus@lowmanfamilydental.com
www.lowmanfamilydental.com

Chart #. ____
FOR OFFICE USE ONLY

Patient Name: ____ Last ____ First ____ MI ____ Preferred Name

Title: ____ Mr/Ms/Mrs/etc Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ____ SS #. ____ Prev. Visit: ____

Email Address: ____ Best time to call: ____

Phone: ____ Home ____ Work ____ Ext ____ Mobile ____ Fax ____ Other

Address: ____ ____
____ City ____ State ____ Zip Code

Emergency Contact Person/Phone number:

____

Primary Dental Insurance/Subscriber Name/Member Number:

* ____

Secondary Dental Insurance/Subscriber Name/Member Number:

____

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Dr. Lowman all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether I have insurance or not. I authorize the use of my signature on all insurance submissions.
Dr. Lowman may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This content will end when my current treatment plan is completed from one year from the date signed below.

Signature: ____________________ Date: ____

Response Date: ____