Lockhart
COSMETIC & FAMILY
Dentistry

DENTAL REGISTRATION AND INSURANCE

PATIENT INFORMATION

Date: _____ SS#: _____ Birthday: _____ Age: _____ Sex: M [ ] F [ ]

Patient Name: _____
LAST *FIRST* *MIDDLE*

Address: _____ City: _____ State:_____ Zip: _____

PHONE NUMBERS & CONTACT INFORMATION

Home: (_____)_____-_____ Work: (_____)_____-_____

Mobile: (_____)_____-_____ E-Mail: _____

Patient Employer/School: _____ Occupation: _____

Employer/School Address: _____ City: _____ State: _____ Zip: _____

Employer/School Phone: (_____)_____-_____

Spouse's Name: _____ Spouse's Employer: _____

Who is responsible for this account? _____

Who may we thank for referring you? _____

In case of emergency, contact: _____ (_____)_____-_____
NAME *RELATIONSHIP* *PHONE*

DENTAL INSURANCE

Name of Insured: _____ Relationship to Patient: _____

Birthdate: _____ SS#: _____ Effective Date: _____

Name of Employer: _____ Employer Phone: (_____)_____-_____

Insurance Name: _____ Insurance Phone: (_____)_____-_____

Insurance Address: _____ City: _____ State: _____ Zip: _____

ID Number: _____ Group Number: _____

Annual Maximum Benefit: _____

Do You Have Any Additional Insurance? Yes [ ] No [ ]

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I certify that I, and/or my dependents have insurance and assign directly to Lockhart Dentistry all insurance benefits. I understand that I am financially responsible for all whether or not paid by insurance.

_____

Signature of Patient, Parent, Guardian or Personal Representative ***Date***

Patient Name: _____ Date: _____

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DENTAL HISTORY

Reason for today's visit: _____
Former Dentist: _____ City: _____ State: _____
Date of last dental visit: _____ Date of last dental x-ray's: _____
How often do you brush? _____ How often do you floss? _____

PLEASE MARK "YES" OR "NO" TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING:

Bad breath	Yes [ ] No [ ]	Jaw pain or tiredness	Yes [ ] No [ ]
Bleeding gums	Yes [ ] No [ ]	Lip or cheek biting	Yes [ ] No [ ]
Blisters on lips or mouth	Yes [ ] No [ ]	Loose teeth or broken fillings	Yes [ ] No [ ]
Burning sensation on tongue	Yes [ ] No [ ]	Mouth breathing	Yes [ ] No [ ]
Chew on one side of mouth	Yes [ ] No [ ]	Mouth pain	Yes [ ] No [ ]
Cigarette, pipe or cigar smoking/chewing tobacco	Yes [ ] No [ ]	Orthodontic treatment	Yes [ ] No [ ]
Clicking or popping jaw	Yes [ ] No [ ]	Pain around ear	Yes [ ] No [ ]
Dry mouth	Yes [ ] No [ ]	Periodontal treatment	Yes [ ] No [ ]
Fingernail biting	Yes [ ] No [ ]	Sensitivity to cold	Yes [ ] No [ ]
Food collection between the teeth	Yes [ ] No [ ]	Sensitivity to heat	Yes [ ] No [ ]
Foreign objects in mouth	Yes [ ] No [ ]	Sensitivity to sweets	Yes [ ] No [ ]
Grinding teeth	Yes [ ] No [ ]	Sensitivity when biting	Yes [ ] No [ ]
Gums swollen or tender	Yes [ ] No [ ]	Sores or growths in mouth	Yes [ ] No [ ]

MEDICAL HISTORY

Physician's Name: _____Phone Number: (_____)_____ Date of last visit: _____
Pharmacy Name: _____Phone Number: (_____)_____

PLEASE MARK "YES" OR "NO" TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING:

AIDS or HIV	Yes [ ] No [ ]	Headaches	Yes [ ] No [ ]	Fainting	Yes [ ] No [ ]
Anemia	Yes [ ] No [ ]	Heart Problems	Yes [ ] No [ ]	Respiratory Disease	Yes [ ] No [ ]
Arthritis	Yes [ ] No [ ]	Hepatitis Type ____	Yes [ ] No [ ]	Scarlet Fever	Yes [ ] No [ ]
Back problems	Yes [ ] No [ ]	Herpes	Yes [ ] No [ ]	Shortness of Breath	Yes [ ] No [ ]
Cancer	Yes [ ] No [ ]	High Blood Pressure	Yes [ ] No [ ]	Sinus Trouble	Yes [ ] No [ ]
Chemical dependence	Yes [ ] No [ ]	Kidney Disease	Yes [ ] No [ ]	Stroke	Yes [ ] No [ ]
Chemotherapy	Yes [ ] No [ ]	Liver Disease	Yes [ ] No [ ]	Swollen Neck Glands	Yes [ ] No [ ]
Circulation Problems	Yes [ ] No [ ]	Low Blood Pressure	Yes [ ] No [ ]	Thyroid Problems	Yes [ ] No [ ]
Cortisone Treatments	Yes [ ] No [ ]	Nervous Problems	Yes [ ] No [ ]	Tonsillitis	Yes [ ] No [ ]
Diabetes	Yes [ ] No [ ]	Persistent Cough	Yes [ ] No [ ]	Tuberculosis	Yes [ ] No [ ]
Emphysema	Yes [ ] No [ ]	Psychiatric Care	Yes [ ] No [ ]	Ulcers	Yes [ ] No [ ]

HAVE YOU EVER HAD OR BEEN DIAGNOSED WITH:

Artificial Heart Valve	Yes [ ] No [ ]	Mitral Valve Prolapse	Yes [ ] No [ ]
Heart Murmur	Yes [ ] No [ ]	Blood Disease	Yes [ ] No [ ]
Artificial Joint/Pins/Screws	Yes [ ] No [ ]	Pacemaker	Yes [ ] No [ ]
Hernia Repair	Yes [ ] No [ ]	Congenital Heart Lesions	Yes [ ] No [ ]
Bleeding abnormally with extractions	Yes [ ] No [ ]	Rheumatic Fever	Yes [ ] No [ ]

HAVE YOU EVER TAKEN ANY OF THESE MEDICATIONS:

Blood Thinners:	
Coumadin	Yes [ ] No [ ]
Warfarin	Yes [ ] No [ ]
Osteoporosis Medications (Bisphosphonates):	
Fosamax	Yes [ ] No [ ]
Actonel	Yes [ ] No [ ]
Boniva	Yes [ ] No [ ]
Evista	Yes [ ] No [ ]
Reclast	Yes [ ] No [ ]
Forteo	Yes [ ] No [ ]

ARE YOU ALLERGIC TO:

Aspirin	Yes [ ] No [ ]
Barbiturates	Yes [ ] No [ ]
Codeine	Yes [ ] No [ ]
Ibuprofen	Yes [ ] No [ ]
Latex	Yes [ ] No [ ]
Local Anesthesia	Yes [ ] No [ ]
Metals	Yes [ ] No [ ]
Penicillin	Yes [ ] No [ ]
Other: _____	

HAVE YOU EVER HAD COMPLICATIONS FOLLOWING DENTAL TREATMENT? YES [ ] NO [ ]
Please explain _____

PLEASE PRINT ALL MEDICATIONS NOW TAKING _____
_____
_____

ARE YOU PREGNANT OR NURSING? YES [ ] NO [ ]

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FINANCIAL POLICY

Thank you for choosing the office of Dr. Bruce Lockhart. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of this mission is making the cost of optimal care as easy and manageable as possible by offering several payment plans.

PAYMENT OPTIONS:

- Cash, Check, Visa , MasterCard, Discover
  ***Lockhart Dentistry Charges $75.00 for a returned check*

- A 10% courtesy will be given when the fee is paid in full prior to treatment.

- Convenient interest free monthly payment plans are available from Care Credit or the Lending Club. It only takes a few minutes to apply. We can do it for you in the office or you can apply at home on their websites, www.carecredit.com and www.lendingclub.com

- If there is an insurance estimate, your portion is due the day of treatment.

- For plans requiring multiple appointments, alternative payment arrangements may be provided.

INSURANCE

As a courtesy to you, we will file with your dental insurance carrier to help you maximize your benefits. The amount not covered by your insurance will be estimated, and you will be required to pay at the time of treatment. If we have not received payment from your insurance company within 60 days you will be responsible for full payment of your treatment. You can then collect directly from your insurance carrier. Ultimately, you are responsible for all fees not paid by your insurance.

COLLECTIONS

I agree to pay treble damages if I cash any insurance or other check that represent reimbursement to Practice for services rendered, and I fail to immediately tender the monies due to Practice. I agree and understand in the event I do not pay practice the balance due and my account is placed in the hands of a collection agency and/or attorney for collection proceedings, I will be legally responsible for all costs of collection, including but not limited to: collection agency fees, including those derived as a percentage of outstanding balance, court costs, litigation expenses, attorney's fees, as well as other incidental expenses incurred by Practice, and further I consent to the jurisdiction of the Small Claims Court or Superior Court of Marion County, Indiana and agree that Indiana law governs all matters arising out of this agreement.

If you have any questions, please do not hesitate to ask. We are here to help you get the best dentistry you want or need, and find the best financial solution for you.

Patient, Parent or Guardian Signature ***Printed Patient Name*** ***Date***

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PATIENT HIPAA CONSENT FORM

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination, and test results. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a means by which a third party payer can verify that services billed were actually provided
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand the Notice of Information Practices provides a more complete description of information uses and disclosures.
I understand that I have the right to review the notice prior to signing this consent.
I understand that the organization reserves the right to change their notice and practices and prior to implementations will mail a copy of any revised notice to the address I've provided.
I understand that I have the right to object to the use of my health information for directory purposes.
I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that the organization is not required to agree to the restrictions requested.
I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Signed this _____ day of _____ , 20_____.

Print Patient Name _____

Signature _____

Relationship to Patient _____