Lockwood Family Dental Care | Erbab Majeed D.D.S.
16 W Lockwood Avenue Webster Groves, MO 63119 | www.lockwoodtooth.com
info@lockwoodtooth.com | p. (314) 961-0020 f. (314) 961-2165 |

## PATIENT INFORMATION

NAME:_____PREFERRED NAME/NICKNAME:_____

BIRTH DATE:_____SS#:_____ ☐ MALE ☐ FEMALE

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

HOME PHONE:_____CELL PHONE:_____WORK PHONE: _____

EMAIL:_____MAY WE CONTACT YOU BY TEXT? Y / N

CHECK APPROPRIATE BOX: ☐ SINGLE ☐ MARRIED ☐ MINOR

EMPLOYER/SCHOOL:_____OCCUPATION:_____

SIGNIFICANT OTHER NAME:_____PHONE:_____

EMERGENCY CONTACT:_____RELATIONSHIP TO PATIENT: _____

EMERGENCY CONTACT PHONE: _____

***If someone referred you, please let us know who to thank! How did you hear about us? *** _____

_____

## RESPONSIBLE PARTY INFORMATION

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT?_____

RELATIONSHIP TO PATIENT: ☐ SELF ☐ PARENT ☐ SPOUSE ☐ OTHER _____

ADDRESS:_____EMAIL: _____

PHONE: _____ SIGNATURE OF RESPONSIBLE PARTY: _____

_____

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*YOU MAY REFUSE TO SIGN ACKNOWLEDGEMENT*

**REFER TO THE ACCOMPANYING NOTICE OF PRIVACY PRACTICES. COPIES ARE AVAILABLE BY REQUEST.**

I authorize this office to leave messages on my answering machine or with a family member. I authorize this office the use of mail reminders. I authorize the release of information (including x-rays) to other doctors/dentist by my request or on my behalf. I understand that written notification is required if I request that you treat my information in a manner not listed above or in your privacy policy.

**SIGNATURE**:_____**DATE**: _____

**FOR OFFICE USE ONLY**

☐ Patient Refused to Sign ☐ Communications barriers prohibited obtaining the acknowledgement. ☐ Other: _____

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**DENTAL INSURANCE INFORMATION** ☐ **Check box if NO dental insurance**

PLEASE PRESENT YOUR CARD TO THE FRONT DESK **(AND)** FILL THIS AREA OUT COMPLETELY

*We will verify that you are in network before any treatment is administered*

**PRIMARY INSURANCE POLICY (Please confirm that this is your primary policy)**

NAME OF POLICY HOLDER (THIS WILL NOT ALWAYS BE THE PATIENT): _____

RELATIONSHIP OF POLICY HOLDER TO PATIENT: _____

BIRTHDATE OF INSURED: _____ SS# OF INSURED: _____

EMPLOYED BY: _____ WORK PHONE: _____

INSURANCE COMPANY: _____ (Please present card to be scanned)

---

*IF YOU HAVE SECONDARY INSURANCE, PLEASE CONFIRM WITH YOUR INSURANCE COMPANIES WHICH IS PRIMARY AND WHICH IS SECONDARY. FAILURE TO DO SO WILL DELAY CLAIMS, RESULTING IN OUT OF POCKET EXPENSES*

**SECONDARY INSURANCE POLICY (Please confirm that this is your secondary policy)**

NAME OF SECONDARY POLICY HOLDER: _____ RELATIONSHIP: _____

BIRTHDATE: _____ SS#: _____

EMPLOYED BY: _____ WORK PHONE: _____

INSURANCE COMPANY: _____ (Please present card to be scanned)

# INSURANCE POLICY

As your dental care provider, our relationship is with you, the patient, and not your insurance company. Your insurance policy is a contract between you, and your insurance company. As a courtesy to our patients, we will complete insurance forms and submit claims for services provided on your behalf; however, ***patients are directly responsible for all incurred charges*** – including the ones their insurance does not cover.

As a courtesy to our patients, we provide a recommended treatment plan. This plan includes the **estimated** out-of-pocket expenses for the patient and is not a guarantee of insurance coverage. **The estimated out-of-pocket expense is collected on the day services are rendered.**

By signing, you acknowledge that you may receive less of a benefit than we estimate for you. You are responsible for knowing what your insurance does and does not cover, and **you are responsible for paying for services your insurance carrier does not cover.**

By signing below, you agree that you have read this section and authorize our office to accept an assignment of benefits from your insurance company.

**SIGNATURE:** _____ **DATE**: _____

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# FINANCIAL POLICY

## PATIENTS WITHOUT DENTAL INSURANCE

**Cost of treatment is due the day service is rendered.**

## PATIENTS WITH DENTAL INSURANCE

1. Patient is responsible for providing our office with correct and updated insurance information. If we are not given the correct insurance information and are unable to process your claims after 30 days, you will become responsible for the full cost of treatment.
2. Patient is responsible for knowing their insurance benefits.
3. Work completed at another office or with a specialist will affect available benefits. Reduced benefits will also impact our estimates. Check with your insurance company to verify frequency limitations and exclusions.
4. *Estimated patient portion is due the day service is rendered***.** When a patient chooses to utilize insurance to help pay, we can only **estimate** the balance due to us.
5. You are responsible for charges not covered by your dental benefits.

## ALL PATIENTS

1. For your convenience, we accept cash, checks made payable to "Lockwood Family Dental Care", MasterCard, Visa, Discover, American Express and Care Credit.
2. Our approved payment plan option is Care Credit. Please ask us about Care Credit for more information.
3. Any outstanding balance over 60 days will be charged a $25 late payment fee.
4. A fee of $50 is charged for patients who miss or cancel more than 2 times in a 12 month period without a 24 (business) hour notice.
5. There will be a $30 fee charged on all returned checks.

By signing, you agree that you have read this section and accept full financial responsibility for all charges and fees incurred related to any and all services provided. In the event of default of payment on this account or any future accounts you may have, you understand that your treatment plan may be suspended until your balance is resolved. Balances greater than 120 days past due may be submitted to a third party collections agency for resolution.

**SIGNATURE:**_____ **DATE:** _____

You may also pre-authorize us to charge your credit card for balances on your account not covered by your insurance company: I authorize Greeneville Dental Associates, P.C. to keep my signature on file and charge my account for balance of charges not paid by insurance within 45 days and not to exceed $_____for:

☐ All visits this year ☐ recurring charges (ongoing treatments) of $_____ every_____from_____to_____

Cardholder name:_____Billing address: _____

Billing Zip:_____ Card Type: MC____Visa____Discover____AM Express____Care Credit ___ Card Exp. Date _____

Card #_____CVV code: _____

Cardholder Signature:_____Date:_____

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# CONSENT

## General Consent

I,_____, request and authorize the staff and dentist of Lockwood Family Dental Care to perform necessary dental services including but not limited to x-rays, local anesthetics and treatment advised by the dentist. I understand that in the process of being treated, the recommended procedure may need to be modified to achieve a more clinically successful result.

**SIGNATURE (Must be signed by legal guardian if patient is under 18)**:_____
Parents/guardians: you must be present in the reception area during the entire course of the appointment for your child/minor.

DATE: _____

## CONSENT TO RELEASE INFORMATION

**If you are of age and wish to allow us to speak with another person (ex: spouse, parent, grandparent, child, friend…) on your behalf please complete the section below.**

I,_____request and authorize Lockwood Family Dental Care to release/discuss information about my health care and accounts to:

Name:_____Relationship:_____Phone: _____

Name:_____Relationship:_____Phone: _____

Name:_____Relationship:_____Phone: _____

Name:_____Relationship:_____Phone: _____

****PLEASE NOTE** At least 48 hours notice must be given to transfer records/radiographs successfully.**

This authorization must be verified annually. Permission may be revoked or amended at any time by written request.

**SIGNATURE of patient or patient's authorized representative:** _____

**Relationship if signed by parent, legal guardian, etc.:** _____

**DATE of signature**: _____

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# MEDICAL HISTORY

**MEDICATIONS**

Please list all current medications: (you may alternately provide us with a list and we will scan it for you).

_____

_____

Preferred Pharmacy:_____Pharmacy phone: (____) _____

**ALLERGIES**

Do you have any Allergies to: ☐ Penicillin ☐ Latex ☐ Acrylic ☐ Local Anesthetics

☐ Food ☐ Aspirin ☐ Codeine ☐ Metals (Earrings)

Please list any other Allergies: _____

Are you now under the care of a physician? ☐ Yes ☐ No

If yes, please explain: _____

Name of physician:_____

Phone: _____

Have you been advised by your physician to take any type of pre-medication before dental treatment due to a pre-existing medical condition? ☐ Yes ☐ No

Women: Are you pregnant or trying to get pregnant? ☐ Yes ☐ No

Due Date, if pregnant:_____

*To our patients on contraceptives: Antibiotics can interfere with birth control and render them ineffective. If this is relevant to you, please exercise other avenues of contraception as you deem appropriate/necessary.

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**Please mark all medical conditions that apply to you with an "X" to the right of the condition. There is a space below for you to explain any conditions you have marked with an "X". Conditions noted with an asterisk may require antibiotic premedication.**

| | | | | | |
|---|---|---|---|---|---|
| **AIDS/ HIV Positive** | | **Alcoholism** | | **Alzheimer's Disease** | |
| **Anaphylaxis** | | **Anemia** | | **Arthritis/ Gout** | |
| **Artificial Heart Valve *** | | **Artificial Joint** | | **Asthma** | |
| **Cardiac Stent (past 12 months)** | | **Bronchiectasis** | | **Cancer:_____** | |
| **Chronic Obstructive Pulmonary Disease** | | **Chronic Bronchitis** | | **Congestive Heart Failure** | |
| **Cold Sores/Fever Blisters** | | **Congenital Heart Disorder *** | | **Emphysema** | |
| **Diabetes** | | **Drug Addiction** | | **Fainting Spells/Dizziness** | |
| **Endocarditis in Past *** | | **Epilepsy or Seizures** | | **Heart Attack/Failure** | |
| **Fibromyalgia** | | **Glaucoma** | | **Hepatitis A, B or C (which one)__** | |
| **Heart Trouble/Disease** | | **Hemophilia (Bleeding Disorders)** | | **Immune Diseases** | |
| **Herpes** | | **HPV** | | **Immune Diseases** | |
| **Kidney Disease (Dialysis)** | | **Lasix Eye Surgery (Past 2 months) (N)** | | **Middle Ear Infection** | |
| **Lupus** | | **Macrocytic Anemia** | | **Pacemaker** | |
| **Organ Transplant** | | **Osteoporosis** | | **Rheumatoid Arthritis** | |
| **Psychiatric Care** | | **Respiratory Diseases** | | **Joint Replacement** | |
| **Ulcerative Colitis** | | **Crohn's Disease** | | **Irritable Bowel Syndrome** | |
| **Irritable Bowel Disease** | | **Head and Neck Radiation** | | | |

If needed, please explain any of the conditions you marked with an "X" above or any other medical conditions you feel need clarification:_____

_____

_____

_____

_____

**To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform Lockwood Family Dental Care of any changes in medical status, dental treatments from other providers, changes of legal guardianship, and changes in any of my dental benefits.**

**Signature of Patient or Guardian:_____Date:_____**