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#:____________________

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 (If patient is also responsible party, skip section)

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT?______________________________

RELATIONSHIP TO PATIENT: ☐ PARENT ☐ SPOUSE ☐ OTHER __________________

ADDRESS:____

EMAIL: ____

PHONE: ____________________ (NOTE: Responsible party may be contacted regarding your account)

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 reminders via phone, email, and/or text. 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

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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MEDICAL HISTORY

General

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.

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 allergies to any of the following?:

Penicillin	☐	Latex	☐	Acrylic	☐	Local Anesthetic	☐
Food	☐	Aspirin	☐	Codeine	☐	Metals	☐

Please note and/or explain any of the allergies you have:

____

____

____

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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.

Condition		Condition		Condition	
AIDS/HIV		Alcoholism		Alzheimer's Disease	
Anaphylaxis		Anemia		Arthritis/ Gout	
Artificial Heart Valve *		Artificial Joint		Asthma	
Cardiac Stent		Bronchiectasis		Cancer:_______________	
COPD		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	
Heart Trouble/Disease		Hemophilia (Bleeding Disorders)		Immune Diseases	
Herpes		HPV		Immune Diseases	
Kidney Disease (Dialysis)		Lasix Eye Surgery (Past 2 months)		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, changes in privacy preferences, and changes in any of my dental benefits.

Signature of Patient or Guardian:_____________________________________**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, etc.) on your behalf please complete the section below. Please refer to our privacy policy to further see how your information is protected and/or used in our office.

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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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.

For the purposes of this document "we", "us", "our", "the practice" refer to Lockwood Family Dental Care and "you" and "your" refer to the patient.

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 August 27, 2018, 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.

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 and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and 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.

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 (with your written authorization): 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 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 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 use or disclose your health information to provide you with appointment reminders (such as voicemail messages, 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 health information). We may charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format.

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, but not before August 27, 2018. 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 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 location, 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.

Electronic Notice: If you receive this Notice on 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 :

Lockwood Family Dental Care
16 W Lockwood Ave
Webster Groves, MO 63119
info@lockwoodtooth.com

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 above. 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.