Dennis R. Lockney, DDS
New Patient Information

DATE: _____

First Name: _____ **Middle Initial:** ____ **Last Name:** _____

Preferred Name: _____ **e-mail Address:** _____

Address: _____ **Apt#** _____ **City:** _____ **State:** _____ **Zip Code:** _____

Home #: _____ **Work #:** _____ **Ext**_____ **Cell#:** _____

Marital Status: (Married___) (Single ___) (Other___) **Date Of Birth :** _____

Social Security #:_____-_____-_____ **Drivers License#:** _____

FT College Student: (Y___/N___) Employer: _____ **Occupation:** _____

RESPONSIBLE PARTY INFORMATION

First Name: _____ **Middle Initial:** ____ **Last Name:** _____

Relationship to Patient: _____

Address: _____ **Apt#** _____ **City:** _____ **State:** _____ **Zip Code:** _____

Home #: _____ **Work #:**_____ _____ **Ext**_____ **Cell#:**_____

e-mail Address:_____ **Marital Status:(Married__)(Single __)(Other__)** **Date of Birth:** _____

Social Security#: _____-_____-_____ **Drivers License#:**_____

Employer:_____ **Occupation:** _____

DENTAL INSURANCE INFORMATION

Dental Insurance Co. Name: _____ **Address:**_____

City: _____ **State:** _____ **Zip Code:** _____ **Employer:** _____

Insured's Name (As appears on card.): _____

Insured's SSN: _____-_____-_____ **Date of Birth:** _____ **Group#** _____ **ID#**_____

DO YOU HAVE DUAL COVERAGE? (Y___N___) .....If yes, complete the following.

Secondary Insurance Co. Name:_____ **Address:** _____

City: _____ **State:** _____ **Zip Code:** _____ **Employer:** _____

Insured's Name (As appears on card.): _____

Insured's SSN: _____-_____-_____ **Date of Birth:** _____ **Group#**_____ **ID#**_____

Who may we thank for referring you to our office? _____

Dennis R. Lockney, DDS

DENTAL & MEDICAL HISTORY

Date: _____ **Patients full name:** _____

Name of previous Dentist: _____ **Date of last dental visit:** _____

Reason for last dental visit: _____ **Date of last X-rays:** _____

What do you like most about your smile? _____

What do you like least about your smile? _____

Are you interested in whitening your smile? _____

How many times a day do you brush? _____ **Have you ever noticed any bleeding when brushing? Y___N___**

How often do you floss? _____ **Have you ever noticed any bleeding when flossing? Y___N___**

How often do you change your toothbrush? _____

Have you ever had complications with dental treatment? Y___N___ If yes, explain _____

_____

Reason for this visit: _____

PLEASE CHECK ANY OF THE FOLLOWING HEALTH CONDITIONS THAT APPLY TO YOU:

*Allergic to: ____Latex ____Penicillin ____Sulfa

____Codeine ____Levaquin Other: _____

____Pacemaker/Defibrillator	**____Diabetes**	**____Heart Disease**	**____TMJ**
____Rheumatic Fever	**____Hepatitis A,B or C**	**____Heart Murmur**	**____Stroke**
____HIV/AIDS	**____Epilepsy/Seizures**	**____High Blood Pressure**	**____Anxiety**
____Asthma	**____Arthritis**	**____Low Blood Pressure**	**____Alcohol Use**
____Stint Placed	**____Sinus Problems**	**____Abnormal bleeding**	**____Drug Use**
____Cancer	**____Radiation**	**____Chemotherapy**	**____Anemia**

Do you smoke cigarettes? Y____N____. If yes, how often? _____

Joint Replacement? Y____N____. If yes, when? _____

Do you have to take antibiotic prior to dental visits? Y____N____. If yes, what antibiotic? _____

If female, are you pregnant? Y____N____. If yes, how far along are you? _____

Have you been hospitalized in the past 2 years? Y____N____. If yes, explain. _____

Are you under a physicians care now? Y____ N____. If yes, explain. _____

List all medications that you take on a regular basis: _____

Physician's Name and Phone#: _____/_____

Preferred Pharmacy and Phone#: _____/_____

IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT?

Name: _____ **Home#** _____ **Cell#** _____

SIGNATURE (of patient or legal guardian) _____ **Date:** _____

For office use: **Dentist Signature:** _____ **Date:** _____
Comments:

Dennis R. Lockney, DDS

Financial Policy

Our caring staff is constantly striving to provide our patients with the latest technology and professional services available. Our primary goals are to customize a treatment plan that best suits your dental needs: medically, esthetically and financially; to take care of your dental needs in a timely manner; and to make every visit to our office as comfortable as possible for you.

Dental Insurance

Dental Insurance is an employee benefit and is intended to help pay towards dental treatment according to a fee schedule set by each insurance company / policy and is up to you to understand your policy and its limitations. As a courtesy, we will file your insurance claims if you have provided a copy of the insurance card and we are able to verify benefits. Please be aware that we are given a breakdown of benefits in a very generic form, and all quotes are ***estimates*** only. Ultimately, you are also responsible for any and all charges that are returned as denied or non-covered once your claim has been submitted and processed by your insurance provider. If you feel that your claim was inaccurately denied for something other than a filing error on our part, it is your responsibility to dispute this directly with your insurance provider. You will be responsible for any remaining balance on your account at that time. If the claim is later resolved by your insurance company, we will refund any amount due to you.

Payment Options

We accept Cash, Personal Checks, Visa, MasterCard, Debit Cards and **Care Credit**.

(An additional fee of $25.00 will be applied to your account for returned checks.)

Care Credit is a medical credit card accepted at most medical facilities and offers both ***no interest and low interest plans.***

You would utilize your Care Credit card to pay your dental bill here in full, then make monthly payments to Care Credit.

You may choose to apply for Care Credit here in our office; you will need to provide us a copy of your driver's license and a major credit card; as per the request of Care Credit Co. Or you may choose to apply from home using the internet by visiting our website; www.drlockney.com where you will find a link to **Care Credit.**

Outstanding Balances

Account balances **60 days** or more past due must be paid in full.
If your account balance becomes **90 days** or more past due; your account will be sent to collections. An additional charge of 25% of the current balance will be added to the balance due. This new balance must be paid in full before any other appointments are scheduled.

Please print, sign and date below, this indicates that you have read, understand and agree to the terms of our Financial Policy.

_____ _____

(Patient Name) (Signature)

_____

(Date)

HIPPA AGREEMENT
Dennis R. Lockney, DDS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of privacy practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purpose that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected health information" is information about you including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

1. **Use and Disclosures of Protected Health Information** Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in thee waiting room when your physician is ready to see you, we may use or disclose your protected health information, as necessary, to contact you of your appointment.

We may use or disclose your protected health information in the following situations with out your authorization. These situations include: as: Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: legal proceedings: law Enforcement: Coroners, Funeral Directors, and Organ Donation; Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with requirements of section 164.500.
Other Permitted and required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to object unless required by law.
You may revoke this authorization, at any time, in writing, except to the extent that your physician or physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights Following is a statement of your rights with the respect to your protected health information.
You have the right to Inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.
You have the right to request a restriction of your protected health information. This means you may ask us to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. *You* may also request that any part of your protected health information not to be disclosed to family members or friends who may be involved in your care or for notification purpose as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Health care Professional.

You have the right to request confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. Upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
We reserve the right to change the terms of this of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints You may complain to us or to the secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint.

We will not retaliate against you for filing a complaint.
This notice was published and becomes effective on/or before **April 23, 2003.**
We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by the phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name_____ **Signature**_____ _____ Date _____