

PATIENT QUESTIONNAIRE - LARRY Z. LOCKERMAN, DDS

Patient's name: _____ Date of birth ___/___/___
Residence Address: _____ Telephone #(____)_____
Business Phone: _____ Cell Phone: _____
City, State _____ Zip: _____ S.S.#: _____-____-____
Patient's Employer (or parent's): _____ Phone: (____)_____
Work Phone: (____)_____ Cell Phone(____)_____
Employer address: _____ City, State: _____ Zip: _____
Person responsible for this account: _____
Relationship: _____
How will account be paid? Cash, Check, Credit Card
Driver License State _____ #: _____
Name of Medical Insurance Company: _____
Plan ID# _____

Polcy Holder _____ Employer: _____
Who referred you to this office? _____

In the following questions, circle yes or no, which ever applies. Your answers are for our records only and will be considered confidential.

- 1. Are you in good health -----yes---no
2. Has there been any change in your general health within the past year -----yes---no
3. my last physical examination was on (date)_____
4. Are you now under the care of a physician? -----yes---no
5. The name and address of my physician is

- 6. Have you had any serious illness or operations? -----yes---no
7. If so what was the problem? _____
8. Do you have any of the following problems or diseases?
a. Damaged heart valves or artificial heart valves including heart murmur-yes--no
b. congenital heart problems -----yes--no
c. cardiovascular disease (heart trouble, attack, artery blockage, high blood pressure, arteriosclerosis, stroke -----yes--no
1. Do you have chest pain with exertion?-----yes--no
2. Are you ever short of breath after mild exertion?-----yes--no
3. Do your ankles swell?-----yes--no
4. Do you get short of breath when you lie down?-----yes--no
5. Do you require an extra pillow to sleep?-----yes--no
6. Do you have a cardiac pacemaker?-----yes--no
d. Allergies?-----yes--no
1. Sinus trouble-----yes--no
2. Asthma or hay fever?-----yes--no
3. Hives or skin rash?-----yes--no
e. Fainting spells or seizures?-----yes--no
f. Diabetes?-----yes--no
1. Do you have to urinate (pass water)more that 6 times a day?---yes--no
2. Are you thirsty much of the time?-----yes--no
3. Does your mouth frequently become dry?-----yes--no
g. Hepatitis, jaundice or liver disease?-----yes--no
h. Arthritis?-----yes--no
i. Inflammatory rheumatism (painful swollen joints)? -----yes--no
j. Stomach ulcers?-----yes--no
k. Kidney trouble?-----yes--no
l. Tuberculosis?-----yes--no
j. Do you have persistent cough or cough up blood?-----yes--no
k. Low blood pressure?-----yes--no
l. venereal disease?-----yes--no
m. Herpes virus (periodic sores)?-----yes--no
n. Epilepsy?-----yes--no
o. Cancer?-----yes--no
p. AIDS or other immunosuppressive disorders?-----yes--no
q. Other _____

9. Have you had any abnormal bleeding with previous extractions, surgery or trauma?---yes--no

a. Do you bruise easily?-----yes--no
b. have you had blood transfusions?-----yes--no, If yes explain: _____

Please turn the page over

10. Do you have any blood disorders such as anemia?-----yes--no

11. Have you had any surgery, X-rays or drug treatment for your head and neck area?--yes--no

12. Are you taking any drug or medicine?-----yes--no

If so what_____

13. Are you taking any of the following: (please list name and dose)

a. Antibiotics or sulfa drugs:_____ g. Aspirin:_____

b. Anticoagulants (blood thinners)_____ h. Insulin, tolbutamide or similar_____

c. High blood pressure medicine_____ i. Cortisone (steroids)_____

d. Digitalis or heart trouble meds_____ j. Nitroglycerine_____

e. Tranquilizers:_____ k. Oral Contrceptives_____

f. Antihistamines:_____ l. Other_____

14. Are you allergic or have you reacted adversely to:

a. Local anesthetics (Novocain or others) -yes--no e. Penicillin or other antibiotics-yes--no

b. Sulfa drugs-----yes--no f. Barbiturates or sedatives-- ----yes--no

c. Sleeping pills-----yes--no g. Aspirin, or Motrin-----yes--no

d. iodine-----yes--no h. Codeine or other narcotics-----yes--no

Others not listed_____

15. Have you had any serious trouble associated with any dental treatments?_____

16. Do you have any problems with "TMJ" or pain with moving your jaw-----yes--no

a. do you wear any retainers day or night time-----yes--no

b. does your jaw joint (TMJ) click or make noise-----yes--no

c. do you have pain in the area of your ears often-----yes--no

17 Do you have headaches-----yes--no

a. Have you been treated for headaches-----yes--no

b. if yes what was done and what medication was prescribed?_____

18 Are you wearing any removable dental appliances or dentures?-----yes--no

WOMEN

19. Are you pregnant?-----yes--no

20. Are you nursing?-----yes--no

**CONSENT FOR TREATMENT & TO RELEASE MEDICAL INFORMATION
& AUTHORIZATION FOR INSURANCE CLAIMS CONSENT FOR TREATMENT**

1. I hereby and voluntary consent to such procedures, including diagnostic and treatment, as may be deemed necessary by Dr. Lockerman and his associates.

2. I acknowledge that no guarantees have been made to me as a result that may be obtained.

3. I understand that I have the right to question, discuss or refuse any or all tests and/or treatment.

4. This form has been explained to me and I understand its contents.

CONSENT TO RELEASE MEDICAL/DENTAL INFORMATION AND AUTHORIZATION TO PAY INSURANCE BENEFITS

1. I authorize the release of any medical information necessary to process my insurance claims and necessary information for billing statements.

2. I authorize the release of my name to identify work sent to medical and dental laboratories.

3. I authorize and request payment directly to Dr. Larry Lockerman, of medical/dental benefits otherwise payable to me. They will not exceed Dr. Lockerman's regular charges.

4. I understand that I am financially responsible to Dr. Lockerman for any deductible, co-insurance or non-covered services.

5. I agree this authorization will cover all medical/dental services rendered until such authorization is revoked by me by written notification.

6. I authorize the use of the contents of my records for educational purposes or for research activities provided that my identity is not revealed in conducting the study.

7. I agree that a photocopy of this form may be used in lieu of the original.

Signed:_____ Date_____

Patient's name, or responsible party, (Printed)