

**PATIENT QUESTIONNAIRE - LARRY Z. LOCKERMAN, DDS**

Patient's name: \_\_\_\_\_ Date of birth \_\_\_/\_\_\_/\_\_\_  
 Residence Address: \_\_\_\_\_ home phone # (\_\_\_\_) \_\_\_\_\_  
 City, State \_\_\_\_\_ Zip: \_\_\_\_\_ S.S.#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Business Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Patient's Employer (or parent's): \_\_\_\_\_ 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 \_\_\_\_\_ Birthday \_\_\_\_\_  
 Employer: \_\_\_\_\_ City, State \_\_\_\_\_  
 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

**IN THE FOLLOWING QUESTIONS PLEASE CIRCLE YES OR NO,**

**Constitutional Systems Ear/Nose and Throat**

Fever Y N  
 Chills Y N  
 Headache Y N  
 Weight change Y N

Hearing loss Y N  
 Stuffy/ Runny Nose Y N  
 Sinus infection Y N  
 Allergy/ Hay Fever Y N

**Neurological**

Stroke Y N  
 Seizure Y N  
 Head Injury Y N  
 Memory loss Y N

**Respiratory**

Chronic Cough Y N  
 Shortness of Breath Y N  
 Wheezing Y N

**Gastrointestinal**

Abdominal Pain Y N  
 Nausea/ vomiting Y N  
 Heartburn Y N

**Psychiatric**

Depression Y N  
 Anxiety Y N  
 Panic attacks Y N

**Cardiovascular**

Chest Pain Y N  
 Palpitations Y N  
 Fainting Spells Y N

**Endocrine**

Diabetes Y N  
 Thyroid problem Y N  
 Hormone treatment Y N

**Genitourinary**

Increase night urination Y N  
 Hot flashes Y N

**Eyes**

Glaucoma Y N  
 Dry Eyes Y N

Do you need to take antibiotics for dental treatment? Yes.....NO

- 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**

- 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) \_\_\_\_\_