REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date_____

SS#_____

Patient Name_____

Address_____

City_____State_____Zip_____

How Long?_____ Rent ☐ Own ☐

E-mail_____

Sex ☐M ☐F Age_____

Birth Date_____

☐Married ☐Widowed ☐Single ☐Minor

☐Separated ☐Divorced ☐Partnered For____Years

Occupation_____

Spouse's Name_____

Spouse's Birth Date_____

Spouse's SS#_____

Spouse's Employer_____

Whom may we thank for referring you?_____

_____

Acknowledgement of Receipt of Notice of Privacy Policies

I,_____,have received a copy of Dr. Charles F. Lockhart, DDS, Notice of Privacy Policies. I understand Dr. Charles F. Lockhart, DDS may use my health care information and may disclose such information for: treatment, payment, and health care operations.

_____Printed Name

_____ Signature & Date_____

2 DENTAL INSURANCE

Who is financially responsible for this account?

_____

Relationship to Patient_____

Insurance Co._____

Group#_____

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber's Name_____

Birth Date_____ SS#_____

Relationship to Patient_____

Insurance Co._____

Group #_____

Insurance Assignment

I certify that I, and/or my dependents(s), have insurance coverage with_____and assign directly to hh Dr Charles F. Lockhart, DDS all insurance benefits, if any, otherwise payable to me for services rendered.

Financial and Personal Health Information

I understand that I am financially responsible for all charges incurred during treatment. I further understand that any insurance contract is between my insurance carrier and myself, Dr. Charles F. Lockhart, DDS are not part of that contract. As a courtesy to our valued patients we will submit your insurance forms initially. If problems occur with insurance portion of your obligation, the balance in full will become due in 30 days. We will provide information to help you deal with your carrier. I understand that finance charges will begin 60 days from date of service if the balance is not paid in full. I authorize the use of my signature on all insurance submissions.

_____

Signature of Patient, Parent, Guardian or Personal Representative

_____

Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____

Date Relationship to Patient

3 PHONE NUMBERS

Home (_____)_____Work (_____)_____Ext _____ Cell Phone (_____)_____

Spouse's Work (_____)_____Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name_____ Relationship_____

Home Phone (_____)_____ Work Phone (_____)_____

4 HEALTH HISTORY UPDATE

To be updated at your future dental visits

Date Of Visit	Changes To Health History / Medication	Detail Changes Initials
1._____	YES_____ NO_____	_____
2._____	YES_____ NO_____	_____
3._____	YES_____ NO_____	_____

5 DENTAL HISTORY

Reason for today's visit_____
Former Dentist_____
City/State_____
Date of last dental visit_____
Date of last dental X-rays_____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad Breath	☐Yes	☐No
Bleeding Gums	☐Yes	☐No
Blisters on lips or mouth	☐Yes	☐No
Burning sensation on tongue	☐Yes	☐No
Chew on one side of mouth	☐Yes	☐No
Cigarette, pipe, or cigar smoking	☐Yes	☐No
Clicking or popping jaw	☐Yes	☐No
Dry Mouth	☐Yes	☐No
Fingernail Biting	☐Yes	☐No
Food collection between the teeth	☐Yes	☐No
Foreign Objects	☐Yes	☐No
Grinding Teeth	☐Yes	☐No
Gums swollen or tender	☐Yes	☐No
Jaw pain or tiredness	☐Yes	☐No
Lip or cheek biting	☐Yes	☐No
Loose teeth or broken fillings	☐Yes	☐No
Mouth Breathing	☐Yes	☐No
Mouth pain, brushing	☐Yes	☐No
Orthodontic Treatment	☐Yes	☐No
Pain around ear	☐Yes	☐No
Periodontal Treatment	☐Yes	☐No
Sensitivity to cold	☐Yes	☐No
Sensitivity to heat	☐Yes	☐No
Sensitivity to sweets	☐Yes	☐No
Sensitivity when biting	☐Yes	☐No
Sore or growths in your mouth	☐Yes	☐No

How often do you floss?_____
How often do you brush?_____

6 HEALTH HISTORY

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐Yes	☐No	Epilepsy	☐Yes	☐No	Respiratory Disease	☐Yes	☐No
Anemia	☐Yes	☐No	Fainting or Dizziness	☐Yes	☐No	Rheumatic Fever	☐Yes	☐No
Arthritis, Rheumatism	☐Yes	☐No	Glaucoma	☐Yes	☐No	Scarlet Fever	☐Yes	☐No
Artificial Heart Valves	☐Yes	☐No	Headaches	☐Yes	☐No	Shortness of Breath	☐Yes	☐No
Artificial Joints	☐Yes	☐No	Heart Murmur	☐Yes	☐No	Sinus Trouble	☐Yes	☐No
Asthma	☐Yes	☐No	Heart Problems	☐Yes	☐No	Skin Rash	☐Yes	☐No
Back Problems	☐Yes	☐No	Hepatitis Type_____	☐Yes	☐No	Special Diet	☐Yes	☐No
Bleeding abnormally, with extractions or surgery	☐Yes	☐No	Herpes	☐Yes	☐No	Stroke	☐Yes	☐No
Blood Disease	☐Yes	☐No	High Blood Pressure	☐Yes	☐No	Swollen Feet or Ankles	☐Yes	☐No
Cancer	☐Yes	☐No	Jaundice	☐Yes	☐No	Swollen Neck Glands	☐Yes	☐No
Chemical Dependency	☐Yes	☐No	Jaw Pain	☐Yes	☐No	Thyroid Problems	☐Yes	☐No
Chemotherapy	☐Yes	☐No	Kidney Disease	☐Yes	☐No	Tonsillitis	☐Yes	☐No
Circulatory Problems	☐Yes	☐No	Liver Disease	☐Yes	☐No	Tuberculosis	☐Yes	☐No
Congenital Heart Lesions	☐Yes	☐No	Low Blood Pressure	☐Yes	☐No	Tumor or growth on head or neck	☐Yes	☐No
Cortisone Treatments	☐Yes	☐No	Mitral Valve Prolapse	☐Yes	☐No	Ulcer	☐Yes	☐No
Cough, Persistent/Bloody	☐Yes	☐No	Nervous Problems	☐Yes	☐No	Venereal Disease	☐Yes	☐No
Diabetes	☐Yes	☐No	Pacemaker	☐Yes	☐No	Weight Loss (unexplained)	☐Yes	☐No
Emphysema	☐Yes	☐No	Psychiatric Care	☐Yes	☐No			
			Radiation Treatment	☐Yes	☐No			

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:_____

_____

_____

Pharmacy Name_____

Phone (___)_____

ALLERGIES

☐Aspirin
☐Barbiturates (Sleeping pills)
☐Codeine
☐Iodine
☐Latex
☐Local Anesthetic
☐Penicillin
☐Sulfa
☐Other_____

_____