Dr. Stephen Lockwood, DMD, MAGD
4150 Regents Park Row, #230 La Jolla, CA 92037

(Patient confidentiality is respectfully observed)

Name:____________________________________ Preferred Name:____________________ Birthdate:________________
Address:____ City:___________________ State:_____ Zip:__________
Home Phone: _______________ Cell Phone: _______________
Whom may we thank for referring you?____
Person to contact in case of emergency:__________________________ Relationship: ____________Phone:__________

Students Only: College:____ Major:_________________________________
Parent/Spouse's Name:____ Best Phone #:___________________________

Patient's Employer:____ Work Phone:_____________
Address:____ City:___________________ State:_____ Zip:__________

Person Responsible for This Account: ____Relationship:_____________
Is this person currently a patient in this practice? (Y / N)
Address:____ City:___________________ State:_____ Zip:__________
Birthdate: _______________SSN: _______________ Phone: _______________ Driver's License #:_______________

Dental Insurance Information

Name of Insured (Policyholder):____ Relationship:________________
Insured's Birthdate:___________________________ SSN:________________________
Name of Employer:____Work Phone:________________
Address:____ City:___________________ State:_____ Zip:__________
Dental Insurance Co.: __________________________________Group #: _______________Union or Local #:___________

Secondary Dental Insurance Information

Name of Insured (Policyholder):____ Relationship:________________
Insured's Birthdate:___________________________ SSN:________________________
Name of Employer:____Work Phone:________________
Address:____ City:___________________ State:_____ Zip:__________
Dental Insurance Co.: __________________________________Group #: _______________Union or Local #:___________

Medical Insurance Information

Some diagnostic and treatment services in our practice are billable through medical insurance. These include digital panoramic and 3D Cone Beam CT radiographs and most surgical procedures. You are giving us permission to bill your medical insurance carrier as your primary insurance and any existing dental benefits as your secondary insurance where applicable. **This may allow the policyholder to have more of their dental insurance maximum benefit available.**

Name of Insured (Policyholder):____ Relationship:________________
Insured's Birthdate:___________________________ SSN:________________________
Name of Employer:____Work Phone:________________
Address:____ City:___________________ State:_____ Zip:__________
Dental Insurance Co.: __________________________________Group #: _______________Union or Local #:___________
Medicare (Y / N) Medicare ID: ___________________________

(Please complete the reverse side)

Patient Medical History

Physician/Hospital:________________________ Office/Hospital Phone: _______________Date of last exam:___________

Are you currently under medical treatment? N Y Describe:____

Have you ever been hospitalized for any surgical operation or serious illness? N Y Describe:_________________________

Please list any medication(s) you are taking (including OTC medicines):____

Have you ever taken biphosphonates for your bones (e.g. Fosemax, Boniva) N Y Please List: _________________________

Do you use tobacco? N Y Frequency:____________________ Do you use alcohol? N Y Frequency: ____________________

Do you use cocaine, marijuana, or other drugs? N Y Frequency:___________________________

Do you wear contact lenses? N Y

Are you allergic or sensitive to any antibiotics? N Y Please List:____

Are you allergic or sensitive to codine? N Y

Are you allergic or sensitive to latex? N Y

Are you allergic or sensitive to local anesthetics or epinephrine? N Y

Are you allergic or sensitive to anti-inflammatory agents (e.g. Advil, aspirin) N Y Please List:_________________________

Are you allergic to any of the following?: N Y nitrous oxide, sedatives, iodine or other: _____________________________

Please circle N for No and Y for Yes to the following conditions:

Dementia	N Y	Leukemia	N Y	Stomach problems/Ulcers	N Y
Depression	N Y	Diabetes (type I, II)	N Y	Liver Disease	N Y
Psychological Problems	N Y	Kidney Disease	N Y	Tuberculosis	N Y
High Blood Pressure	N Y	Thyroid Problem	N Y	Glaucoma	N Y
Low Blood Pressure	N Y	Cancer/Tumor	N Y	Recent Weight Loss	N Y
Heart Attack	N Y	Radiation Therapy	N Y	Respiratory Problems	N Y
Stroke	N Y	Musculoskeletal Problems	N Y	Easily Winded	N Y
Angina	N Y	Arthritis	N Y	Emphysema	N Y
Cardiac Pacemaker	N Y	Auto-Immune disease	N Y	Asthma	N Y
Heart Murmur	N Y	Joint Replacement	N Y	Fatigue	N Y
Mitral Valve Prolapse	N Y	STD	N Y	Anemia	N Y
Rheumatic Fever	N Y	Hepatitis (A, B, C)	N Y	Hay Fever/Allergies	N Y
Fainting/Convulsions	N Y	HIV/AIDS	N Y	Other:________________________	
Epilepsy/Seizures	N Y	Herpes (Oral, other)	N Y	______________________________	

Women only: Are you pregnant, think you are pregnant or trying to become pregnant? N Y

If pregnant, how many months?________ Are you nursing? N Y

Patient Dental History

Why are you here today?____

Please circle N for No and Y for Yes to the following:

Are you satisfied with the appearance of your teeth or smile?	N Y	Have you ever been informed that you have gum disease?	N Y
Do your gums bleed when brushing or flossing?	N Y	Do you have frequent headaches?	N Y
Are your teeth sensitive to cold or hot liquids/food?	N Y	Do you clench or grind your teeth?	N Y
Do you feel pain from any of your teeth?	N Y	Do you bite your lips/cheeks often?	N Y
Do you have any sores/lumps in your mouth?	N Y	Were your wisdom teeth removed?	N Y
Have you had any trauma to your head, face, neck, or jaw?	N Y	Prolonged bleeding with extractions?	N Y
		Have you had orthodontic treatment?	N Y
Related to your jaw: Have you had any clicking?	N Y	Is food impacting between your teeth?	N Y
Have you had any pain?	N Y	Have you had sedation dentistry?	N Y
Do you have limited opening?	N Y	Do you snore?	N Y
Do you have any difficulty chewing?	N Y	Do you have halitosis (bad breath)?	N Y

Have you ever had a bad experience in a dental office? Please describe:____

____

Name of last dentist:________________________ Date of last cleaning: ____________Date of last X-Rays:____________

Authorization and Diagnostic consent: I have read and understand the above information. I consent to all diagnostic aids deemed necessary by Dr. Lockwood and his staff. I understand that I am responsible for payment of dental services. I also understand I may pay a finance charge of 18% annually for any balance over 45 days and any collection costs and attorney fees to affect collection of this balance.

Signature of Patient, Guardian or Parent if a minor:__________________________________ **Date:**__________________

Dr. Stephen Lockwood, DMD, MAGD
Financial Policy

Welcome to our practice! We are pleased you have selected us to assist you with your dental needs. Our aim is to provide you with personalized quality dental care. If you have any questions regarding your treatment, please bring it to our attention. We would like to introduce you to our office financial policy.

Payment for service is required at the time of your visit. This helps to reduce our overhead costs resulting in lower fees for our patients. For your convenience we accept cash, checks, MasterCard Visa, Discover and American Express. If you have dental insurance, we will be happy to assist you in filing a claim and in determining your benefits. Bring your insurance card with you to your visit. We will keep it on file for subsequent visits. Please notify us of any changes in your coverage.

All co-payments and deductibles are due when services are rendered. You are directly responsible to our office for payment of your account, regardless of the status of your insurance claim. You will receive a statement each month from our office even if your insurance payment is pending. The estimate provided by this office is to be used only as a guideline until the final insurance payment is received and the patient's account has been reconciled. *An estimate is no guarantee of the insurance payment, as is clearly stated by the insurance company. However we are here to assist you receive the best care and the most from your benefits.

If we have filed your insurance claim on your behalf and no payment of "denial of benefits" notice has been received within 30 days, we encourage you to contact your insurance company as to the reason for the delay. *If your insurance has not pain within 45 days, we will require that you clear your balance. Meaning, you must pay your account balance in full and instruct your insurance company to reimburse you directly. See below.

We are happy to work with patients who do not have insurance. Financial arrangements may be made available for large cases on an individual basis.

The best dental care can be provided only on the basis of mutual understanding. We therefore encourage our patients to discuss any questions they have regarding our financial policy with our staff.

*I understand that I am directly responsible for all dental services regardless of insurance benefits should my account go over 45 days from the date of service.

Patient Name:____

Patient Signature:____

Date:____

(Optional) If you would like to retain payment information, please fill out the following:

(Please circle one): **American Express** **Visa** **MasterCard** **Discover**

Name on Card:____

Credit Card #:____

Expiration Date:_________________ Security Code:_________________ Billing Zip Code:____________________

Dr. Stephen Lockwood, DMD, MAGD
Acknowledgement of Receipt of Notice of Privacy Practices

(YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT)

By signing below I acknowledge that I have read and received a copy of this office's Notice of Privacy Practices.

Patient name:____

Patient Signature:____

Date:____

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prevented obtaining acknowledgement
- ☐ An emergency situation prevented obtaining acknowledgement
- ☐ Other (Please specify):____

Dental Materials Fact Sheet

By signing below I acknowledge I have read a copy of the Dental Materials Fact Sheet. I have had the opportunity to discuss this information with my dentist prior to the placement of further dental restorative work.

Patient name:____

Patient Signature:____

Date:____

Dentist Signature:____

(Copies of this form will be retained in the patient's chart.)

Dr. Stephen Lockwood, DMD, MAGD
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.

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 _____/______/_____, 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 new Notice available on request. You may request a copy of our Notice at any time. For more information about our Privacy Practices, or for additional copies of this Notice, please let our office staff know.

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

Healthcare Operations: We may use or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence of 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 consent 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 you 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: 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 you 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 care 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 your 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 or 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 institutions or

law enforcement officials 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, 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 your request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form from our office to request access to your records. Our office does not charge a fee for providing your healthcare information.

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, for the last 6 years, but not before April 14, 2003. 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 office 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 location. You must make your request in writing. Your request must specify that 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 email, you are entitled to receive this notice in written form.

If you want more information about our Privacy Practices or have questions or concerns, please contact us.

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 through alternative means or at alternative location, you may complain to us using the contact information provided at the end of this Notice. You may also 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.

Contact: Stephen Lockwood, DMD, Inc. Privacy Officer
4150 Regents Park Row, #230
La Jolla, CA 92037
Phone: (858) 558-3050
Fax: (858) 558-3053
Email: drstevedmd@sbcglobal.net