**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**

| | | |
|---|---|---|
| Fever | Y | N |
| Chills | Y | N |
| Headache | Y | N |
| Weight change | Y | N |

**Ear/Nose and Throat**

| | | |
|---|---|---|
| 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 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)_____________________________________