Alison W. Lockhart, DMD

5107 Trenholm Road • Columbia, SC 29206
Phone 803.782.9030 • Fax 803.569.1505

PATIENT INFORMATION

DATE_____

NAME_____ SSN# _____
Last First Middle

ADDRESS _____
Number and Street City State Zip Code

HOME PHONE_____ CELL PHONE _____

EMAIL_____ (Circle One) MARRIED SINGLE MINOR

WHAT ARE THE BEST WAYS TO REACH YOU?_____

GENDER (Circle One) **M** or **F** DATE OF BIRTH_____ AGE _____

EMPLOYER_____ WORK PHONE _____

EMPLOYER ADDRESS _____
Number and Street City State Zip Code

OCCUPATION _____

SPOUSE/GUARDIAN_____ SSN#_____ DOB _____

EMPLOYER_____ WORK PHONE _____

EMPLOYER ADDRESS _____
Number and Street City State Zip Code

IN CASE OF EMERGENCY, CONTACT_____ PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

PHARMACY_____ PHONE_____

DENTAL INSURANCE

PRIMARY CARRIER (Circle One) Self Spouse Parent

SUBCRIBER NAME _____

SUBCRIBER SSN# _____

SUBCRIBER DOB _____

INS. COMPANY _____

PHONE # _____

ADDRESS_____

POLICY# _____

GROUP# _____

SECONDARY CARRIER (Circle One) Self Spouse Parent

SUBCRIBER NAME _____

SUBCRIBER SSN#_____

SUBCRIBER DOB _____

INS. COMPANY _____

PHONE#_____

ADDRESS _____

POLICY#_____

GROUP#_____

I understand that my insurance is an agreement between my insurance company and me. I understand that I am responsible for the ballance of my dental account regardless of my insurance. I assign dental benefits to be paid directly to Alison Lockhart, DMD, PA from my insurance company. I give permission for my dentist or his/her clinician team to take any necessary diagnostic, films, photos, or study models to properly enable complete diagnosis and treatment.

Patient's/Parent's Signature_____ Date _____

Alison W. Lockhart, DMD

5107 Trenholm Road • Columbia, SC 29206
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DATE_____

NAME_____ SSN# _____
Last First Middle

Health History

Please check the box beside any of the medical conditions you have experienced

- ❑ Alcohol/Drug Abuse
- ❑ Anemia
- ❑ Angina
- ❑ Arthritis
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Bleeding Disorders
- ❑ Cancer/Tumor
- ❑ Cardiovascular Disease
- ❑ Diabetes
- ❑ Digestive Disorders
- ❑ Drug Allergies
- ❑ Epilepsy/Seizures (last seizure)
- ❑ Fever Blisters/Herpes
- ❑ Glaucoma
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ High Blood Pressure
- ❑ HIV/AIDS
- ❑ Hormone Problems
- ❑ Hypoglycemia
- ❑ Kidney Problems
- ❑ Low Blood Pressure
- ❑ Lung Disease
- ❑ Mitral Valve Prolapse
- ❑ Pneumonia
- ❑ Psychiatric Disorders
- ❑ Radiation Therapy
- ❑ Respiratory Disease
- ❑ Rheumatic Fever
- ❑ Shortness of Breath
- ❑ Sinus Problems
- ❑ Stomach Ulcers
- ❑ Stroke
- ❑ Smoker
- ❑ Thyroid Problems
- ❑ TMJ Pain
- ❑ Tuberculosis
- ❑ Excessive Anxiety with Dental Treatment

Have you ever taken bisphosphates (osteoporosis drugs)?_____ Do you wear a pacemaker?_____

Please list all allergies _____

Do you have any artificial joints, implanted devices or heart valves? _____

Please list all medications you are currently taking _____

_____

Are you required to take antibiotics prior to routine dental care? _____

If you have a medical condition not listed above, please describe _____

_____

Physician's Name_____ Phone Number _____

Women: Are you pregnant?_____ Nursing?_____ Taking oral contraceptions?_____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payments of all services rendered on my behalf or my dependents.

Patient's/Parent's Signature_____ Date _____

GENERAL INFORMATION-PLEASE READ

In an effort to avoid any confusion, we would like to provide the following information. It is our hope that this will answer most of the questions or concerns you may have regarding our financial policies. If you have additional questions, please do not hesitate to ask. If you would like a copy of this form, please ask at the front desk.

Payment IS DUE ON THE DAY OF SERVICE. Please be prepared to pay for your dental treatment on the day of service. We accept cash, check, Visa, MasterCard, Discover, American Express and CareCredit.

INSURANCE: We will file any Dental insurance as a courtesy to our patients. We make no guarantee of coverage by insurance but will verify insurance benefits. The portion of the treatment not estimated to be covered by the primary dental insurance is due on the day service. If insurance has not paid after 60 days from the date of service, the balance becomes the responsibility of the patient. If you have any questions or concerns regarding your coverage please contact your insurance carrier directly. If you need to know what your insurance will cover for a specific procedure we can file a pre-treatment estimate. ANY PORTION NOT COVERED BY INSURANCE IS THE RESPONSIBILITY OF THE PATIENT. **If you are a new patient and you do not have your insurance information with you, payment will be due in full.**

Delta Dental: **WE ARE AN IN NETWORK PROVIDER For DELTA DENTAL PREMIER.**

Medicaid/Medicare: WE DO NOT FILE WITH MEDICAID OR MEDICARE.

Financing: We offer financing with CareCredit. CareCredit provides options that we cannot offer directly through our office. CareCredit offers the flexibility of making low monthly payments over time. If you are interested in CareCredit, please ask the front office for more information. (Credit Approval required)

RETURNED CHECKS: THERE IS A $35.00 FEE FOR ANY RETURNED CHECK, If a patient has two returned checks, we will no longer accept any personal checks. Payment must be made by cash, credit card or certified funds.

BROKEN/MISSED APPOINTENTS: In order to provide the best possible service and availability to all our patients, we reserve the right to charge for missed/cancelled appointments (less than 24 hour notice). Monday appointments must be cancelled by close of business on the prior Thursday to avoid being subject to the fee. Please call us as early as possible to reschedule your appointment. If a patient has two or more broken appointments in a six month period we will not be able to schedule any further appointments. Instead, the patient will be placed on an "on-call" list.

Appointments with the doctor: The fee for missing or canceling an appointment with less than 24 hour notice is 20% of the scheduled procedure(s) fee.

Appointments with the hygienist: The fee for missing or canceling an appointment with less than 24 hour notice is $55.00 for a routine cleaning appointment. The fee for other types of hygiene work (ex. Root planning, Full mouth debridement) is 20% of the scheduled procedure(s) fee.

LATE ARRIVAL: We regret that late arrivals may not be served in full. If you arrive more than 15 minutes late, your appointment may have to be rescheduled. We will make every attempt to keep your appointment, but feel we must be fair to the next person scheduled.

PAST DUE ACCOUNTS: When an account is over 90 days past due, it will be turned over to a collection agency. The patient will be placed in a "dismissed" status until the balance, including any fees, is paid in full. Once the balance is paid, payment will be due in full on the day of service for all future appointments and we will no longer accept insurance assignment.

THIRD PARTY ACTION: If a third party action becomes necessary, the financial responsible party agrees to pay all fees to include: $75.00 processing fee if turned over to a collection agency, court costs and attorney fees.

SIGN BELOW INDICATING YOU HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE STATEMENTS

Signature_____ Date_____

PLEASE NOTE: WE RESERVE THE RIGHT TO CHANGE ANY OF THE ABOVE WITHOUT NOTICE (rev. 19)

LOCKHART DENTAL
HIPAA COMPOUND AUTHORIZATION FORM

Patient Name: _____ **DOB:** _____

_____ (Please Initial) I authorize **Lockhart Dental** to contact me and/or leave message about an appointment or account information by:
____home ____work ____cell ____text ____email.

Personal Information:

_____ (Please Initial) I authorize the following people (spouse, parents, caretaker, etc.) to have access to my information. **For teens 18 yrs and older, parents will not have access to your information without authorization:**

- Name:_____

  DOB: _____ Relation: _____

  ____ Dental/Clinical ____ Insurance ____ Billing

- Name:_____

  DOB: _____ Relation: _____

  ____ Dental/Clinical ____ Insurance ____ Billing

- Name:_____

  DOB: _____ Relation: _____

  ____ Dental/Clinical ____ Insurance ____ Billing

X-RAYS and Treating Information:

_____ (Please Initial) I authorize **Lockhart Dental** to send unencrypted x-rays and treating information to referral offices via email/phone for additional treatment. (This includes: Endodontist, Oral Surgeons, Periodontist, Orthodontist, etc..)

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that I have the right to revoke this authorization at any time by sending a written notification to the office of Lockhart Dental. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that the information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

_____Date_____
Signature of Patient or Personal Representative (as defined by HIPAA)

Office Use Only:

Receiving Employee _____Date_____

_____ Copy scanned in chart and given to patient

Alison W. Lockhart, D.M.D.
5107 Trenholm Road
Columbia, SC 29206
803-782-9030 fax 803-790-0294

Release of Records

I, _____, (date of birth _____)
hereby authorize Dr. Alison W. Lockhart to obtain my dental records. These records may include x-rays, treatment notes, charting, medical and dental history, photographs, or other notations relevant to my treatment.

These records may be obtained from:

Dental Practice: _____
Address _____
City _____ State _____ Zip _____
Phone number _____

Signature _____ Date _____