LIGHTHOUSE DENTAL

REGISTRATION FORM & HEALTH HISTORY

TODAY'S DATE: _____

PATIENT'S NAME: Last:_____First:_____Middle Initial:_____Sex: M F BIRTHDATE:_____ AGE: _____

SOCIAL SECURITY #:_____If Patient is a Minor, give Parent or Guardian's Name:_____# where you can be reached: _____

MAILING ADDRESS: Street:_____Apt #:_____City:_____State:_____Zip: _____

PREFERRED CONTACT #:_____ (Home / Cell / Work) ALTERNATE CONTACT #_____ (Home / Cell / Work)

EMAIL ADDRESS: _____Who May We Thank for Referring You to our Office?

Reason for Visit: _____

RESPONSIBLE PARTY INFORMATION

NAME: Last:_____First:_____Middle Initial:_____Sex: M F BIRTHDATE:_____ AGE: _____

SOCIAL SECURITY #:_____EMPLOYER:_____ NO. YEARS EMPLOYED: _____

MAILING ADDRESS: Street:_____Apt #:_____City:_____State:_____Zip: _____

PREFERRED CONTACT #:_____ (Home / Cell / Work) ALTERNATE CONTACT #_____ (Home / Cell / Work)

EMAIL ADDRESS: _____RELATION TO PATIENT: _____

RESPONSIBLE PARTY'S SPOUSE

NAME:_____

EMPLOYER:_____ # YEARS EMPLOYED: _____

SOC. SEC. #: _____BIRTHDATE: _____

PREFERRED CONTACT #:_____ (Home / Cell / Work)

EMERGENCY INFORMATION: PLEASE LIST A LOCAL CONTACT (Not Living With You)

NAME:_____RELATIONSHIP:_____

PREFERRED CONTACT #:_____ (Home / Cell / Work)

ADDRESS:_____

CITY/STATE/ZIP: _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

INSURED'S NAME: _____

INSURANCE COMPANY: _____

INSURANCE COMPANY ADDRESS: _____

INSURED'S EMPLOYER: _____

INSURED'S SOCIAL SECURITY #: _____

INSURED'S DATE OF BIRTH: _____

SECONDARY INSURANCE – (Filed as a courtesy. NOT ACCEPTED as a Copay.)

INSURED'S NAME: _____

INSURANCE COMPANY: _____

INSURANCE COMPANY ADDRESS: _____

INSURANCE'S EMPLOYER: _____

INSURED'S SOCIAL SECURITY #: _____

INSURED'S DATE OF BIRTH: _____

PAYMENT ALTERNATIVES (Please Check Appropriate Box:)

☐ 1. Cash and personal checks are accepted as your treatments are provided.

2. If you have dental insurance, we want you to receive the full benefit of it. Our office staff can assist you in completing your insurance forms and verifying the coverage that your particular program provides. We accept assignment of your insurance payment and will gladly file your claims. This means that you are responsible for your deductible and your estimated copayment at time of treatment. Remember that you are still responsible for the account if the insurance company, for any reason, does not honor their commitment to you and to us.

☐ 3. Mastercard, Visa and Discover

☐ 4. For long term or extended payments, we offer a healthcare financing program, which when you are accepted, will allow extended small monthly payments for the treatment received.

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account or refunded to me if I have paid the dental fees incurred. I further understand that a 1.5% service charge will be added to any overdue balance each month. I also understand that where appropriate, credit reports may be obtained.

Date:_____ PATIENT SIGNATURE (Or Guardian of Child):_____

DENTIST SIGNATURE:_____

It is important that I know about you Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking time to completely fill out this questionnaire.

DENTAL HISTORY

	Yes	NO
HOW LONG SINCE you have seen a Dentist?		
Last COMPLETE Dental Exam, Date:		
Last FULL MOUTH X-RAYS, Date:	(18 Small Films or Panoramic)	
Are you having PROBLEMS now?	☐	☐
Explain:		
Is your present dental health POOR?	☐	☐
Do you wear DENTURES? (Partials or Full)	☐	☐
Are you UNHAPPY with your dentures?	☐	☐
Would you like to know more about PERMANENT REPLACEMENTS?	☐	☐
Are you APPREHENSIVE about dental treatment?	☐	☐
Have you had any PERIODONTAL (GUM) treatments?	☐	☐
Do your gums BLEED, or feel TENDER or IRRITATED?	☐	☐
Are your teeth SENSITIVE to hot, cold, sweets, or pressure? (circle which one(s))	☐	☐
Are you UNHAPPY with the APPEARANCE of your teeth?	☐	☐
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Do you have HEADACHES, EARACHES, or NECK PAINS?	☐	☐
Have you worn BRACES on your teeth? (ORTHODONTICS)	☐	☐
Do you have DISCOLORED teeth that bother you?	☐	☐
Would you like your smile to LOOK BETTER or DIFFERENT?	☐	☐
Do you REGULARLY use DENTAL FLOSS?	☐	☐
Name of Previous Dentist: City:	State:	

MEDICAL HISTORY

	Yes	NO
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIAN'S CARE now?	☐	☐
For What?		
What MEDICATIONS are you currently taking?		
Are you or do you think you may be PREGNANT?	☐	☐

Do you use cigars/cigarettes, pipe or chewing tobacco? (circle)	☐ ☐
PREFERRED PHARMACY NAME:	PHARMACY #:

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

Heart Disease or Attack	Heart Surgery	Liver Disease	Chemotherapy (Cancer, Leukemia)	Allergies or Hives
Angina Pectoris	Artificial Joints	Blood Transfusion	Venereal Disease	Diabetes
High Blood Pressure	Anemia	Drug Addiction	(Syphilis, Gonorrhea, etc.)	Thyroid Disease
Heart Murmur	Stroke	Hemophilia (Bleeding Problems)	Bruise Easily	Radiation Treatment
Rheumatic Fever	Kidney Trouble	Fever Blisters	Emphysema	Arthritis
Congenital Heart Lesions	Ulcers	Epilepsy or Seizures	Tuberculosis (TB)	Cortisone Medicine
Mitral Valve Prolapse	A.I.D.S./A.R.C./HIV Positive	Nervousness	Asthma	Pain in Jaw Joints
Artificial Heart Valve	Hepatitis A (infectious)	Psychiatric Treatment	Hay Fever	Alcoholism
Heart Pacemaker	Hepatitis B (serum)	Glaucoma	Sinus Trouble	Cosmetic Surgery

Are you allergic to or have you reacted adversely to any of the following medications?

Aspirin Local Anesthetic Erythromycin Nitrous Oxide Codeine Penicillin

Are you aware of being allergic to any other medications or substances? _____

CONSENT TO PERFORM DENTISTRY

1. I hereby authorize and direct the dentist(s) of LIGHTHOUSE DENTAL and/or dental auxiliaries of his/her choice, to perform the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.

    A. Preventive hygiene treatment (prophylaxis) and the application of topical fluoride.
    B. Application of plastic "sealants" to the grooves of the teeth.
    C. Treatment of diseased or injured teeth with dental restorations (fillings and crowns).
    D. Replacement of missing teeth with dental prostheses (bridges, partial dentures, full dentures).
    E. Removal (extraction) of one or more teeth.
    F. Treatment of diseased or injured oral tissue (hard and/or soft).
    G. Use of sedative drugs to control apprehension and/or disruptive behavior.
    H. Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.

2. I understand that there are risks involved in this treatment and hereby acknowledge that these risk(s) will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.

3. I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgement of the doctor(s). Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nose piece leaves an indentation or ring around the nose which disappears shortly after the procedure. I understand and have been informed of the above risks and complications.

4. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedure that are deemed necessary or desirable to oral health and well-being in the professional judgment of the dentist.

5. There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site., fainting lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.

6. I also authorize the doctors to use photograph, radiographs, other diagnostic materials and treatment records for the purposes of teaching, research and scientific publications.

7. I will be advised that the success of the dental treatment to be provided will require that the patients and the parents follow post-operative and post-care instructions of the dentist(s). I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular visits as scheduled by my dentist and his/her auxiliaries must be maintained.

8. I hereby state that I have read and understand this consent, and that all questions about the procedure will be answered in a satisfactory manner; and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.

9. I further understand that this consent will remain in effect until such time that I choose to terminate it.

Date:_____ Time:_____ AM/PM. File No._____

Patient's Name: _____

Name of Parent or Guardian: _____ Relationship to Patient: _____

_____ _____

Signature: Patient or Parent or Guardian Witness

Lighthouse Dental

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

You May Refuse to Sign This Acknowledgement

I,_____, have received a copy of this office's Notice of Policy Practices.

_____

Please Print Name

_____

Signature

_____

Date

I hereby authorize use or disclosure of protected health information about me as described below:

1. The following specific person/class of person/facility is authorized to use or disclose information about me:

   _____

2. The following person (or class of persons) may receive disclosure of protected health information about me:

   _____ _____

   His/Her/Its Name Phone Number

   _____

   Address/City/State/Zip Code

For Office Use Only

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

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ Other (Please Specify)

_____