Lighthouse FAMILY DENTISTRY

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip:

Home Phone: Work Phone: Pager:

Birth Date: Soc Sec: Ext: Cellular:

Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip:

Home Phone: Work Phone: Pager:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed Ext: Cellular:

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail:

☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Pharmacy Ph. #

Pharmacy name

Emergency Contact

Emergency Ph. #

Primary Care #

Primary care name

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

37 Old Solomons Island Road, Annapolis MD 21401
Phone: 410-224-4411 Fax: 410-224-1314
info@lighthousefamilydentistry.com

Financial and Insurance Policy

Payment for Service:
Patients must pay all financial obligations on the date of service. **Treatment that requires pre-fabrication in the lab (lab work) will be paid in full at the time of scheduling. All other treatment plans above $200 will require a 50% deposit when scheduling the appointments and the balance will be due on the date of service.** Patients covered by insurance accepted by our office must assign benefits to Lighthouse Family Dentistry. We will provide an **estimate** of your co-payment and collect that portion at the time of your appointment. **We estimate your responsibility as closely as possible, however until we receive correspondence and/or payment from your insurance company, it is just an estimate. Ultimately, the responsibility lies with you, the patient.** We do our best to obtain payment from the insurance company; however, if your claim is not processed and paid on within 45 days, you will be responsible for the balance in full. **A billing statement will be sent out which you will be responsible to remit payment within 2 weeks of the statement date.** All accounts 60 days past due will be transferred to our collections department for further action.

We accept cash, checks, Visa, MasterCard, Discover and American Express. At this time, we do not offer "in house" payment plans. However, we do offer Care Credit, an outside healthcare financing program that offers interest-free payment plans upon approval. Go to CareCredit.com for more information.

Broken and Failed Appointments:
Your appointment is your responsibility. As a courtesy, our front desk staff will call, text, and/or email you to remind you of your scheduled appointment. If you need to cancel or change your appointment, please notify us at least 3 business days in advance. Cancellations with less than 3 business days notice will incur a fee of $79.

Dr. Meiser and the staff of Lighthouse Family Dentistry believe that clear communication and agreement on financial responsibility is an integral part of caring for our patients. If you have questions, please do not hesitate to ask.

I have read the above policy and agree to accept my financial responsibility as a patient of Lighthouse Family Dentistry.

Patient Name (print):_____

Name of Responsible Party:_____ Date:_____

Office Manager Initials/Date_____

Last Update: 2/8/2023

Time 5:54 PM

Lighthouse Family Dentistry

Eaglesoft Medical History 2023

Patient Name: Birth Date: Date Created: Date 12/27/2022

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	Yes	No	If yes
Have you ever been hospitalized or had a major operation?	Yes	No	If yes
Have you ever had a serious head or neck injury?	Yes	No	If yes
Are you taking any medications, pills, or drugs?	Yes	No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes	No	If yes
Are you on a special diet?	Yes	No	If yes
Do you use tobacco?	Yes	No	
Do you vape?	Yes	No	
Do you use controlled substances?	Yes	No	If yes
Have you ever been diagnose with sleep apnea?	Yes	No	
Do you use a CPAP machine?	Yes	No	

Women: Are you...

Pregnant? Nursing? Taking oral contraceptives?

Are you trying to get pregnant?

Are you allergic to any of the following?

Aspirin | Penicillin | Codeine | Acrylic

Metal | Latex | Sulfa Drugs | Local Anesthetics

Other?

If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Radiation Treatments	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Recent Weight Loss	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Renal Dialysis	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Rheumatic Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Rheumatism	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	High Cholesterol	Yes	No	Scarlet Fever	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hives or Rash	Yes	No	Shingles	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Hypoglycemia	Yes	No	Sickle Cell Disease	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Irregular Heartbeat	Yes	No	Sinus Trouble	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Kidney Problems	Yes	No	Spina Bifida	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Leukemia	Yes	No	Stomach/Intestinal Disease	Yes	No
Breathing Problems	Yes	No	Frequent Headaches	Yes	No	Liver Disease	Yes	No	Stroke	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Low Blood Pressure	Yes	No	Swelling of Limbs	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Lung Disease	Yes	No	Thyroid Disease	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Mitral Valve Prolapse	Yes	No	Tonsillitis	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Osteoporosis	Yes	No	Tuberculosis	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pacemaker	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Yellow Jaundice	Yes	No	Auto Immune Disease	Yes	No						

Have you had COVID in the last 10 days? Yes No

Have you ever had any serious illness not listed above? Yes No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date: _____

Date

Date:

Yes No

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practice, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices

_____
Print Name of Patient/Guardian

_____
Signature

_____
Date

FOR OFFICIAL USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- We were not able to communicate with the patient
- Due to an emergency situation it was not possible
- Other (Please provide specific details)

_____

_____

_____
Employee Signature Date

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices
This form does not constitute legal advice and covers only federal, not state law.