PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient is: ○ Policy Holder
○ Responsible Party

Responsible Party (If someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext. _____ Cellular: _____

Birth Date: _____ Soc. Sec: _____ 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: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext. _____ Cellular: _____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic. _____

E-mail: _____ ○ I would like to receive correspondence 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

Referred by: _____

Previous Dentist: _____

Emergency Contact: _____

Emergency Contact #: _____

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: _____.00 Rem. Deduct: _____.00

MEDICAL HISTORY

PATIENT NAME: _____ Birth Date: _____

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes, please explain _____
Have you ever been hospitalized or had a major operation? Yes No If yes, please explain _____
Have you ever had a serious head or neck injury? Yes No If yes, please explain _____
Are you taking any medications, pills or drugs? Yes No If yes, please explain _____
Do you take, or have you taken Phen-Fen or Redux? Yes No
Are you on a special diet? Yes No
Do you use controlled substances? Yes No

Women: Are you:
Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?:
Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
Other If yes, please explain _____

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

__ AIDS/HIV Positive
__ Alzheimer's Disease
__ Anaphylaxis
__ Anemia
__Angina
__Arthritis/Gout
__Artificial Joint
__ Artificial Heart Valve
__ Asthma
__ Blood Disease
__ Blood Transfusion
__ Breathing Problem
__ Bruise Easily
__ Cancer
__ Chemotherapy
__ Chest Pains
__ Cold Sores/Fever Blisters
__ Congenital Heart Disorder
__ Convulsions
__ Cortisone Medicine
__ Diabetes
__ Drug Addiction
__ Easily Winded
__ Emphysema
__Epilepsy or Seizures
__ Excessive Bleeding
__ Excessive Thirst
__Fainting Spells/Dizziness
__ Frequent Cough
__Frequent Diarrhea
__Frequent Headaches
__ Genital Herpes
__ Glaucoma
__Hay Fever
__ Heart Attack/Failure
__ Heart Murmur
__ Heart Pace Maker
__ Heart Trouble/Disease
__ Hemophilia
__ Hepatitis A
__ Hepatitis B or C
__ Herpes
__ High Blood Pressure
__ Hives or Rash
__Hypoglycemia
__ Irregular Heartbeat
__ Kidney Problems
__ Leukemia
__ Liver Disease
__ Low Blood Pressure
__ Lung Disease
__ Mitral Valve Prolapse
__ Pain in Jaw Joints
__ Parathyroid Disease
__ Psychiatric Care
__ Radiation Treatments
__ Recent Weight Loss
__ Renal Dialysis
__ Rheumatic Fever
__ Rheumatism
__ Scarlet Fever
__ Shingles
__ Sickle Cell Disease
__ Sinus Trouble
__ Spina Bifida
__ Stomach/Intestinal Disease
__ Stroke
__ Swelling of Limbs
__ Thyroid Disease
__ Tonsillitis
__ Tuberculosis
__ Tumors or Growths
__ Ulcers
__ Venereal Disease
__Yellow Jaundice

Have you ever had any serious illness not listed above? Yes No If yes, please explain:_____

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 the patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____

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.

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. All treatment 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:
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 48 hours in advance. Cancellations with less than 48 hours notice will incur a fee.

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: 1/20/2018