LIGHTHOUSE FAMILY
DENTAL CARE
989-631-6760

LET US LIGHT UP YOUR SMILE

# Welcome

Thank you for selecting us.

To help us meet all your healthcare needs,please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

| **Patient information (Confidential)** | | Patient Number |
|---|---|---|
| Name | | Date |
| SS# | Birthdate | Home Phone |

| | | |
|---|---|---|
| Address | City | State / ZIP |
| Email | | Cell Phone |
| Marital Status: | | |

| | | |
|---|---|---|
| If Student Name of School/College | City | State / ZIP |
| Patient or Parent/Guardians' Employer | | Work Phone |

| | | |
|---|---|---|
| Business Address | City | State / ZIP |
| Spouse or Parent Guardian's Name | Employer | Work Phone |
| Whom May We Thank for Refering You? | | |
| Person to Contact in Case of Emergency | | Phone |

**Responsible Party**

| | | |
|---|---|---|
| Name of Person Responsble for this Account | | Relationship to Patient |
| Address | | Home Phone |
| Email | | Cell Phone |
| Drivers License # | Birthdate | Financial Institution |
| Employer | Work Phone | SS# |
| Is this person Currently a Patient in our Office? | | |

For your convenience we offer the following methods of payment, Please check the option prefer.
**Payment in full at each appointment.**
Cash ☐ Check ☐ Credit Card ☐

**Insurance Information**

| | | |
|---|---|---|
| Name of insured | | Relationship to Patient |
| Birthdate | SS# | Date Employed |
| Name of Employer | Union or Local # | Work Phone |
| Employer Address | City | State |
| Insurance Company | Group | Policy / ID# |
| Ins. Co. Address | City | State / ZIP |
| How Much is your Deductible? | How Much Have you Used? | Max Annual Benefit |

Do You Have Any Additional Insurance? If yes, complete the following:

| | | |
|---|---|---|
| Name of insured | | Relationship to Patient |
| Birthdate | SS# | Date Employed |
| Name of Employer | Union or Local # | Work Phone |
| Employer Address | City | State / ZIP |
| Insurance Company | Group | Policy / ID# |
| Ins. Co. Address | City | State / ZIP |
| How Much is your Deductible? | How Much Have you Used? | Max Annual Benefit |

**Dental History**

| Physician: | Office Phone: | Date of Last Exam: |
|---|---|---|

1. Are you under medical treatment now? Yes ☐ No ☐

2. Have you ever been hospitalized for any surgical operation or serious illness within the last five years? Yes ☐ No ☐
If yes, Please explain?________________________________________________
_______________________________________________________________
_______________________________________________________________

medicine?
If yes what medications are you taking? Yes ☐ No ☐
_______________________________________________________________
_______________________________________________________________
_______________________________________________________________
_______________________________________________________________

4.Have you ever taken Fosamax, Boniva Actonel or any other medications containing bisphosphonates? (Osteoporosis Meds) Yes ☐ No ☐

5. Have You Ever Taken Phen-en Redux? Yes ☐ No ☐

6. Do you use Tobbacco? Yes ☐ No ☐

How much & How Long?_____________________________

7. Do you use controlled substances? Yes ☐ No ☐

8. Are you wearing contact lenses Yes ☐ No ☐

9. Has a pyhsician ever told you to take pre-medication prior to a dental appointment? Yes ☐ No ☐
Why? ____________________________________________

10. Are you allergic to or have had any reactions to the following:

| | | |
|---|---|---|
| Acrylic | Yes ☐ | No ☐ |
| Aspirin | Yes ☐ | No ☐ |
| Barbiturates | Yes ☐ | No ☐ |
| Codeine | Yes ☐ | No ☐ |
| Iodine | Yes ☐ | No ☐ |
| Latex | Yes ☐ | No ☐ |
| Local Anesthetics | Yes ☐ | No ☐ |
| Metal | Yes ☐ | No ☐ |
| Penicillin | Yes ☐ | No ☐ |
| Sedatives | Yes ☐ | No ☐ |
| Sulfa Drugs | Yes ☐ | No ☐ |
| Other______________________ | Yes ☐ | No ☐ |

11. Do you have a persisent cough or throat clearing not associated with a known Illness (lasting more than 3 weeks?) Yes ☐ No ☐

**12. Women Only**

Are you pregnant or think you may be pregnant? Yes ☐ No ☐

Are you Nursing? Yes ☐ No ☐

Are you taking oral contraceptives? Yes ☐ No ☐

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

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Aids / HIV Positive | Yes ☐ | No ☐ | Excessive Bleeding | Yes ☐ | No ☐ | Lung Disease | Yes ☐ | No ☐ |
| Alzheimer's Disease | Yes ☐ | No ☐ | Excessive Thirst | Yes ☐ | No ☐ | Mitral Valve Prolapse | Yes ☐ | No ☐ |
| Anaphylaxis | Yes ☐ | No ☐ | Fainting Spells/Dizziness | Yes ☐ | No ☐ | Osteoporosis | Yes ☐ | No ☐ |
| Anemia | Yes ☐ | No ☐ | Frequent Cough | Yes ☐ | No ☐ | Pain in Joints | Yes ☐ | No ☐ |
| Angina | Yes ☐ | No ☐ | Frequent Diarrhea | Yes ☐ | No ☐ | Psychiatric Care | Yes ☐ | No ☐ |
| Arthiritis / Gout | Yes ☐ | No ☐ | Frequent Headaches | Yes ☐ | No ☐ | Radiation Treatments | Yes ☐ | No ☐ |
| Artificial Heart Valve | Yes ☐ | No ☐ | Glaucoma | Yes ☐ | No ☐ | Recent Weight Loss | Yes ☐ | No ☐ |
| Artificial Joint | Yes ☐ | No ☐ | Hay Fever / Allergies | Yes ☐ | No ☐ | Renal Diaylsis | Yes ☐ | No ☐ |
| Asthma | Yes ☐ | No ☐ | Heart Attack / Failure | Yes ☐ | No ☐ | Rheumatic Fever | Yes ☐ | No ☐ |
| Blood Disease | Yes ☐ | No ☐ | Heart Murmur | Yes ☐ | No ☐ | Rheumatism | Yes ☐ | No ☐ |
| Blood Transfusion | Yes ☐ | No ☐ | Heart Pacemaker | Yes ☐ | No ☐ | Scarlet Fever | Yes ☐ | No ☐ |
| Breathing Problem | Yes ☐ | No ☐ | Heart Trouble / Disease | Yes ☐ | No ☐ | Shingles | Yes ☐ | No ☐ |
| Bruise Easily | Yes ☐ | No ☐ | Hemophillia | Yes ☐ | No ☐ | Sickle Cell Disease | Yes ☐ | No ☐ |
| Cancer | Yes ☐ | No ☐ | Hepatitis A | Yes ☐ | No ☐ | Sinus Trouble | Yes ☐ | No ☐ |
| Chemotherapy | Yes ☐ | No ☐ | Hepatitis B | Yes ☐ | No ☐ | Spina Bifida | Yes ☐ | No ☐ |
| Chest Pains | Yes ☐ | No ☐ | Hepatitis C | Yes ☐ | No ☐ | Stroke | Yes ☐ | No ☐ |
| Cold Sores / Fever Blisters | Yes ☐ | No ☐ | Herpes | Yes ☐ | No ☐ | Swelling of Limbs | Yes ☐ | No ☐ |
| Congenital Heart Disorder | Yes ☐ | No ☐ | High Blood Pressure | Yes ☐ | No ☐ | Thyroid Disease | Yes ☐ | No ☐ |
| Convulsions | Yes ☐ | No ☐ | High Cholesterol | Yes ☐ | No ☐ | Tonsillitis | Yes ☐ | No ☐ |
| Cortisone Medicine | Yes ☐ | No ☐ | Hives or Rash | Yes ☐ | No ☐ | Tuberculosis | Yes ☐ | No ☐ |
| Chrohns / Ulcerated Colitis | Yes ☐ | No ☐ | Hypoglycemia | Yes ☐ | No ☐ | Tumors or Growths | Yes ☐ | No ☐ |
| Diabetes | Yes ☐ | No ☐ | Irregular Heart Beat | Yes ☐ | No ☐ | Uicers | Yes ☐ | No ☐ |
| Drug Addiction | Yes ☐ | No ☐ | Kidney Problems / Disease | Yes ☐ | No ☐ | Yellow Jaundice | Yes ☐ | No ☐ |
| Easily Winded | Yes ☐ | No ☐ | Leukemia | Yes ☐ | No ☐ | Other____________ | Yes ☐ | No ☐ |
| Emphysema | Yes ☐ | No ☐ | Liver Disease | Yes ☐ | No ☐ | | | |
| Epilepsy or Seizures | Yes ☐ | No ☐ | Low Blood Pressure | Yes ☐ | No ☐ | | | |

**Dental History**

| Name of Previous Dentist and Location: | Date of Last Exam: | |
|---|---|---|

1. Do your gums bleed while brushing or flossing? Yes ☐ No ☐
2. Are your teeth Sensitive to hot or cold liquids / foods? Yes ☐ No ☐
3. Are your teeth Sensitive to sweet or sour liquids / foods? Yes ☐ No ☐
4. Do you feel pain to any of your teeth? Yes ☐ No ☐
5. Do you have any sore sores or lumps in or near your mouth? Yes ☐ No ☐
6. Have you had any neck or jaw injuries? Yes ☐ No ☐
7. Have you ever experienced any of the following problems in your jaw:
   - Clicking Yes ☐ No ☐
   - Pain (Joint, ear, side of face) Yes ☐ No ☐
   - Difficulty in opening or closing Yes ☐ No ☐
   - Difficulty in chewing Yes ☐ No ☐
8. Do you have frequent headaches? Yes ☐ No ☐
9. Do you clench or grind your teeth? Yes ☐ No ☐
10. Do you bite your lips or cheeks frequently? Yes ☐ No ☐
11. Have you ever had any difficult extractions in the past? Yes ☐ No ☐
12. Have you ever had prolonged bleeding after extractions? Yes ☐ No ☐
13. Have you had orthodontic treatment? Yes ☐ No ☐
14. Do you wear dentures or partials? Yes ☐ No ☐
15. Have you ever received oral hygiene Instructions regarding the care of your teeth and gums? Yes ☐ No ☐
16. Do you like your smile? Yes ☐ No ☐

**Authorized Releases**

I certify that I have read and understand the above information to the best of my knowleldge. 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 any treatment or examination rendered to me or my child during the period of such Dental card to third party payers and / or health practicioners. 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 payment of all services rendered on my behalf or my dependents.Our policy is to charge for appointments that are cancelled with less than 24 Hour notice. If you fail to keep a scheduled appointment, you may be subject to a broken appointment fee.

**X**_________________________________________
**Signature of patient (or parent/guardian if minor)**

Doctor's Comments:

Signature **X**_______________________________________________

Date: