Light House Dental & Orthodontics
Sam B. Richey, D.D.S.
3926 W. 13400 S., Suite F, Riverton, UT 84065
(801) 446-6310

Welcome and thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

Patient Information (Confidential)

Name _____ Birth date _____ Social Security # _____
Home Phone# _____ Cell Phone# _____ Email address _____
Address _____ City_____ State _____ Zip Code _____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Patient's or Parent's Employer_____Work Phone _____
Business Address_____City_____State_____ Zip Code _____
Spouse or Parent's Name___ _____ Employer _____Work Phone _____
Whom May We Thank for Referring You? _____
Person To Contact in Case of Emergency_____Phone_____

Responsible Party

Relationship
Name of Person Responsible for this Account_____ to Patient _____
Address _____ City_____ State_____ Zip Code _____
Driver's License #_____ Birth date_____ Financial Institution _____
Employer_____ Work Phone_____ SS# _____
Is this Person Currently a Patient in our Office? ☐ Yes ☐ No
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full is expected at each appointment. ☐ Cash ☐ Personal Check ☐ Debit Card ☐ VISA ☐ MasterCard ☐ Discover ☐ Outside Financing

Dental Insurance Information

Relationship
Policy Holder's Name_____ to Patient _____
Birth date_____ Social Security #_____ Date Employed _____
Name of Employer _____ Work Phone_____
Address of Employer _____ City_____ State_____ Zip Code_____
Insurance Company_____ Group #_____ Member ID# _____
Insurance Company Address _____ City_____ State_____ Zip Code_____
Customer Service Phone #_____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ☐ Yes ☐ No If Yes, Complete the Following:

Relationship
Name of Insured_____ to Patient _____
Birth date_____ Social Security #_____ Date Employed _____
Name of Employer _____Union or Local #_____ Work Phone_____
Address of Employer _____ City_____ State_____ Zip Code_____
Insurance Company_____ Group #_____Policy # _____
Insurance Company Address _____ City_____ State_____ Zip Code_____

I certify that the above information is accurate according to the best of my awareness. I acknowledge that I may obtain at my request a copy of the "Office Privacy Policies and Procedures" for Light House Dental. I also acknowledge that my questions have been answered to my satisfaction. I understand that if I have questions or concerns I may contact the HIPAA compliance officer of Light House Dental: Mallory at (801) 446-6310.

Name (please print) _____ **Date** _____
Signature _____

Patient Medical History

Patient Name_____ Birth Date_____

Physician_____Office Phone _____Date of Last Exam _____

	Yes	No
1. Are you under a physician's care now?	☐	☐
2. Have you ever been hospitalized or had a major operation within the past 5 years? If yes, please explain _____ _____	☐	☐
3. Have you ever had a serious head or neck injury?	☐	☐
4. Are you taking any medication(s)? including non-prescription medication If yes, what medications are you taking? _____	☐	☐
5. Have you ever taken Phen-Fen/Redux?	☐	☐
6. Are you on a special diet?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐

9. Are you allergic to or have you had any allergic reactions to the following?	Yes	No
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Codeine	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. Nickel, Mercury, etc)	☐	☐
Latex Rubber	☐	☐
Other (please list)_____	☐	☐
10. Women Only:		
a) Are you pregnant or think you may be?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

11. Do you have or have you had any of the following?

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

Have you ever had any serious illness not listed above? ☐Yes ☐No If yes, please explain_____

Patient Dental History

Name of Previous Dentist _____Date of Last Exam_____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking?	☐	☐
Pain (joint, ear, side of face)?	☐	☐
Difficulty in opening or closing?	☐	☐
Difficulty in chewing?	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement _____	☐	☐
15. Have you ever received oral hygiene instructions regarding care of your teeth/gums?	☐	☐
16. Do you like your smile?	☐	☐
If no, what would you change? Color or Shape		

Authorization and Release

I certify that 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 my child or me during the period of such dental care to third party payers and/or health practitioners. I accept the doctor will exercise professional expertise and ability in my best interest. I understand that possible complications may include, but are not limited to pain, bleeding, bruising, infection, tingling and/or numbness of the lips, tongue, gums, and/or face, loss of damage to adjacent teeth or restorations, maxillary sinusitis, mandibular fracture and/or post operative hemorrhage and/or discomfort. Adverse reactions to materials, medicines, anesthetics and procedures are a potential risk in dentistry and I consent to and assume the possible risks.

X_____

Signature of Patient (or parent/guardian if minor)

Doctor's Comments:

_____

_____

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Financial Information

It is our goal to help each of our patients understand the ultimate level of dental health that is achievable for them, and then to help them reach their dental goals by delivering the very highest quality of dental care. Quality comes from a caring attitude combined with technical know how. It is this special combination that enables each patient to reach the ultimate goal of a healthy, happy, beautiful smile.

- *Payment is due at the time of service*. As a condition of treatment by this office, financial arrangements must be made in advance. All emergency dental services, or any dental service performed without previous financial arrangements, must be paid for at the time services are rendered.
  Please initial _____
- As a courtesy to all guests we extend the use of our outside billing service through Care Credit or Capital One. They offer a wide variety of interest-deferred payment options as well as long-term payment plans.
- Due to the complexity of insurance contents, estimated amount(s) are not a guarantee of insurance, or patient payments. Insurance benefits may be subject to, but not limited to, eligibility, plan maximums and limitations, and insurance fee schedules. Patient, or financially responsible person(s) agrees to be responsible for the remaining balance even after insurance have paid their portions.
  Please initial _____
- There is a $35.00 service charge for checks that are returned unpaid.
- Any account balance over thirty (30) days past due will be subject to a $40 monthly late fee. Also, any delinquent account balance over ninety (90) days will be subject to review by our financial coordinator, and a $150 or 40% collection fee (whichever is greater), plus reasonable attorney fees and court costs, will apply to your initial balance and all late fees.
  Please initial _____

Appointment Information

One of our greatest goals is to provide outstanding service, but we do run into those rare occasions when patients fail to keep their scheduled appointments. This puts us in a difficult position having reserved our time for individualized care and can be difficult to fill. We realize that your time is also very valuable. To help prevent broken appointments and provide better service to those patients who keep their commitments, we have implemented the following policies:

- An appointment may be rescheduled if we are given **48 hours** notice before the actual appointment.
- A fee of $40.00 will be charged for failed appointments or those cancelled without 48 hours prior notice. This must be paid before the next appointment is scheduled.
  Please initial _____

Consent to Proceed

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. I understand that any outstanding charges (defined above) in my name will be copied and sent to a financial coordinator's office, and will be subject to court review. I understand that in the event I am unable to be contacted, I will receive a court notice. I agree to be responsible for any and all charges incurred during this process. I am aware that if any changes occur in the information previously provided, I am to notify the office immediately.

I have thoroughly read, completely understand, and agree to cooperate with and abide by the procedures outlined above.

_____ _____
Please print names of all guests you are responsible for, including yourself Date

_____ _____
Signature of Financially Responsible Party Light House Dental Witness