LIGHTHOUSE DENTAL

Dr. Greg Sefcik & Associates

Patient First Name:_____ **Middle Initial**:_____
Last Name:_____

Address:_____
City, State, Zip:_____

Phone Number:(_____)_____ **Email:**_____

Sex: Female [ ] Male [ ] **SSN:**_____ **Date of birth:** (___/_____/___)
Marital Status: Single [] Married[] Divorced[] Widowed[]

Employment Status:	**Employer Info:**	**Student status:**
❑ Full Time	Name:_____	Full time [ ]
❑ Part Time	Number:_____	Part time [ ]
❑ Retired		Not applicable [ ]
❑ Not applicable		

Responsible party:
Self[ ] Mom/Dad [ ] Guardian[ ] (**If self please disregard this section)**
Full name:_____ Patient: Yes[ ] NO [ ]
Phone Number:(_____)_____ DOB:_____

Insurance information:
Policy holder Name:_____ **DOB**:_____/_____/_____
Policy Holder SSN:_____**Phone number**:(_____)_____
Policy Holder Address:_____
Insurance comp:_____**Ins phone number:**(____)_____
Member ID Number:_____
Relationship to policyholder: Parent[ ] Child [ ] Spouse [ ]

Emergency contact:_____**Relationship**:_____
Phone:_____

How did you hear about us?

_____

MEDICAL HISTORY

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

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	
Do you use tobacco?	Yes No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other?	☐	If yes
Do you use controlled substances?	Yes No	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

Have you ever had any serious illness not listed	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:_____

LIGHTHOUSE DENTAL

OFFICE POLICY AND CONSENT FORM

INSURANCE AND PAYMENT POLICIES
FEES FOR SERVICE AT OUR OFFICE WILL BE REQUESTED AT THE TIME OF YOUR VISIT.
For treatment involving fees above $500.00, special financial agreement arrangements may be discussed with our financial coordinator or office manager.
For patients with Dental Insurance:
Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. We will file your claim for you at no charge; however, we ask that your deductibles and your estimated portions be paid as services are rendered. If balance not paid we will contact a collection agency on your behalf on outstanding balances. Although we gladly file dental insurance claims as a courtesy to you, any and all account balances are ultimately your responsibility. Not all services are a covered benefit in all contracts.
Some insurance companies arbitrarily select certain services they will not cover. All insurance benefits are assigned to the Doctor, unless services are paid in full the day of treatment.

OFFICE POLICIES
Your appointment time is set aside especially for you. We ask for the courtesy to the Doctor and to other patients that you keep your scheduled appointments. If you must change or miss an appointment, we require a 48-hour notice. Cancellations, last minute rescheduling or failure to show will result in a broken appointment charge of $65.00, or no reappointment. If more than one family member is scheduled & fails to make their appointment a $65 cancellation fee will be assessed for the first individual and $75 for each family member thereafter. This policy is strictly enforced due to our high volume of patients.
Our office will provide confirmation calls to you. We ask that if we are unable to reach you, that you please contact us as soon as possible to confirm you appointment. Failure to do so may result in your appointment needing to be rescheduled.
We will be fair in working out special finances with you, but please also be fair to us with your commitments. A $25 finance charge will be assessed monthly on all overdue balances.

CONSENT
We reserve the right to dismiss any patient from our practice for inappropriate behaviour in our office or on the phone.
I acknowledge that i am responsible to pay all charges for treatment administered by Lighthouse Dental as outline above and that if my account is placed with a collection agency for non payment that i will be responsible for collection costs including court costs and associated attorney fees.
I have read the policies and agree with the terms above.

Patient/Guardian_____Patient signature_____
Date_____

This notice describes how Medical/Dental Information about you may be used and disclosed and how you can get access to this information. Please read it carefully.
We understand that the privacy of your personal information is important to you. As your Dental office, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to call the office at (303)657-9000

Information We Collect About You
We collect personal information about you and your family as part of our new patient process, during your care, and from other health care entities you utilize such as, other dentists and specialists, imaging facilities, laboratories, and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy, and coverage information and any information you provide. During your treatment we will collect dental information regarding diagnosis, treatment plans, progress, and any test results or films.

How Your Information is Used
The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other Dentists or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian and can be revoked at any time with a written request. Broomfield Dental does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest, we may be required to disclose certain information to local, state, or national health organizations or government agencies. We may contact you to provide appointment reminders or information about treatment.

Safeguarding Your Personal and Health Information
- We are required by law to Make sure that medical information that identifies you is kept private
- Provide you with your privacy policy
- Follow the terms laid out in the Privacy Policy

As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you.

lighthouse dental maintains physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated, you have the right to file a complaint with the Department of Health and Human Services. The complain in no way influences your course of treatment with Broomfield Dental Company.

As of July 1, 2011, the State of Colorado requires that anyone who is prescribed a controlled substance (narcotic) will have their information entered into a nationwide database. The Drug Prescription Monitoring database is very secure, as only physicians and law enforcement can access the database. If you do not wish to have your information entered into this database, please inform the doctor and he will prescribe you a non narcotic

If you have any questions, you can contact the Colorado State Department of Regulatory Agencies by calling (303)894-7855
Changes to Our Privacy Policy. All new patients will receive a copy of notice of privacy policy.Broomfield Dental occasionally reviews its privacy policy and reserves the right to amend it. Notification of changes will be available at the front desk prior to the effective date of any changes.

Your Right to Restrict Use of Information
You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgment

If the patient is under the age of 18, a parent or legal guardian must sign.

I, _____, have received a copy of this office's Notice of Privacy Practices
Signature of Patient or Parent/Legal Guardian: _____
Date: _____

For Patients Who Need to Premedicate Only:

I am authorizing this office to call me and remind me to take my pre-medication before my dental appointment. They may leave a message for me regarding this information at any number that I have supplied to them. They may leave a message on any answering machine, voice mailbox or with whoever answers the telephone.

Printed Name: _____
Signature of Patient or Parent/Legal Guardian: _____

FOR OFFICE USE ONLY

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

Individual refused to sign

o Communications barriers prohibited obtaining the acknowledgement
o An emergency prevented us from obtaining acknowledgement
o Patient reviewed Privacy Practices but elected not to take a copy home
o Other (Please Specify)

Employee Signature: _____
Date: _____