Hello! Thank you for your interest in the Patient FastTrack feature. The following forms will help you to customize your FastTrack page to better fit the needs of your practice. Please start by adding your office contact information below.

Office Name	Office Phone Number	Office email address

Now please check the box next to any field that you would like us to include. If you do not see a field in the list below, we do not currently have that available. Fields cannot be moved from one section to another. Any of these sections can be eliminated completely by not choosing any of the fields within that section.

Basic Patient Info

Patients will type in their info or choose radio buttons depending on the needs of each field.

☐ **Birthdate**	☐ **Sex**	☐ **Preferred name**
☐ **Middle name or initial**	☐ **Marital status**	☐ **Reason for today's visit**

Patient Contact Info

Patients will type in their info or choose radio buttons depending on the needs of each field.

☐ **Email address**	☐ **Address**	☐ **Preferred method of contact**

Emergency Contact Info

Patients will type their info into each field.

☐ **Emergency contact**	☐ **Contact's phone**	☐ **Relationship to Me**

Allergies

Patients will be given a list of potential allergens that they can select from, as well as a "no allergies" option. The "Add Your Own" field will allow them to type in an allergen not found on the list.

☐ **Acetaminophen/Tylenol**	☐ **Acrylic**	☐ **Amoxicillin**
☐ **Aspirin**	☐ **Barbiturates**	☐ **Clindamycin**
☐ **Codeine**	☐ **Erythro**	☐ **General Anesthetics**
☐ **Ibuprofen/Motrin/Advil**	☐ **Iodine**	☐ **Latex**
☐ **Local Anesthetics**	☐ **Metal**	☐ **Novocaine**
☐ **Penicillin**	☐ **Sedatives**	☐ **Sulfa**
☐ **Add Your Own**	☐ **No Allergies**	

Medical Conditions

Patients will be given a list of medical conditions that they can select from, as well as a "no medical condition" option. The "Add Your Own" field will allow them to type in a medical condition not found on the list.

☐ **AIDS/HIV**	☐ **Alzheimer's**	☐ **Anaphylaxis**
☐ **Anemia**	☐ **Angina**	☐ **Anxiety**
☐ **Any Immune Deficiency**	☐ **Any Type of Implant**	☐ **Any Type of Transplant**
☐ **Arthritis**	☐ **Artificial Heart Valves**	☐ **Artificial Joints**
☐ **Asthma**	☐ **Back Problems**	☐ **Bad Breath**
☐ **Bleeding Gums**	☐ **Blood Disease**	☐ **Blood Transfusion**
☐ **Breathing Problems**	☐ **Bruise Easily**	☐ **Bulimia**
☐ **Cancer**	☐ **Cardiovascular Disease**	☐ **Chest Pain**
☐ **Circulatory Problems**	☐ **Clicking in Jaw**	☐ **Congenital Heart Disorder**
☐ **Convulsions**	☐ **Currently Nursing**	☐ **Currently Pregnant**
☐ **Depression**	☐ **Diabetes**	☐ **Difficulty in Chewing**

☐ Difficulty in Opening Jaw	☐ Drug Addiction	☐ Ear Aches
☐ Easily Winded	☐ Emphysema	☐ Epilepsy or Seizures
☐ Excessive Bleeding	☐ Excessive Thirst	☐ Fainting or Dizzy Spells
☐ Finger Nail Biting	☐ Frequent Cough	☐ Frequent Diarrhea
☐ Frequent Headaches	☐ Frequently Tired	☐ G.E. Reflux/Persistent Heartburn
☐ Gastrointestinal Disease	☐ Genital Herpes	☐ Glaucoma
☐ Hay Fever	☐ Head/Neck Injury	☐ Headaches
☐ Heart Attack/Failure	☐ Heart Disease	☐ Heart Murmur
☐ Heart Rhythm Disorder	☐ Heart Surgery	☐ Heart Trouble
☐ Hemophilia	☐ Hepatitis	☐ Hepatitis A
☐ Hepatitis B	☐ Hepatitis C	☐ Herpes
☐ High Blood Pressure	☐ High Cholesterol	☐ Hives or Rash
☐ HPV	☐ Hypoglycemia	☐ Irregular Heartbeat
☐ Jaundice	☐ Kidney Disease	☐ Leukemia
☐ Lip or Cheek Biting	☐ Liver Disease	☐ Loose Teeth or Broken Fillings
☐ Low Blood Pressure	☐ Lung Disease	☐ Mitral Valve Prolapse
☐ Mouth Sores/Growths	☐ Neurological Disorders	☐ Osteopenia
☐ Osteoporosis	☐ Pacemaker	☐ Pain Around Ear
☐ Pain in Your Jaw (TMJ)	☐ Parathyroid Disease	☐ Periodontal Disease
☐ Recent Weight Loss	☐ Recurrent Infections	☐ Renal Dialysis
☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatism
☐ Scarlet Fever	☐ Shingles	☐ Sickle Cell Disease
☐ Sinus Problems	☐ Sleep Apnea	☐ Slow Healing Wounds
☐ Special Diet	☐ Spina Bifida	☐ Stomach Problems
☐ Stroke	☐ Swelling of Limbs	☐ Teeth Grinding/Clenching
☐ Thyroid Disease	☐ Tonsillitis	☐ Tooth Pain
☐ Tooth Sensitivity to Cold or Hot	☐ Tooth Sensitivity to Sour	☐ Tooth Sensitivity to Sweets
☐ Tooth Sensitivity when Biting	☐ Tuberculosis (TB)	☐ Tumors or Growths
☐ Ulcers	☐ Use of Controlled Substances	☐ Use of Tobacco Products
☐ Venereal Disease	☐ Wearing Contact Lenses	☐ Add Your Own
☐ No Medical Condition		

Medical Treatment

Patients will be given a list of potential medical treatments that they can select from, as well as a "not receiving treatments" option. The "Add Your Own" field will allow them to type in a treatment not found on the list.

☐ Chemotherapy	☐ Psychiatric Treatment	☐ Radiation Treatment
☐ Add Your Own	☐ Not Receiving Any Treatments	

Medication

Patients will be given a list of potential medication that they can select from, as well as a "no medications" option. The "Add Your Own" field will allow them to type in a medication not found on the list.

☐ Any Bisphosphonates	☐ Actonel	☐ Boniva
☐ Cortisone Medicine	☐ Fosamax	☐ Oral Contraceptives
☐ Test Medication	☐ Reclast	☐ Add Your Own
☐ No Medications		

Medical History

Patients will type in the pertinent info.

☐ **Physician's name**	☐ **Former dentist's name**	
☐ **Have you had any surgeries, serious illness or hospitalizations recently? (Yes/No toggle)**		☐ **Please Describe: (only if previous was Yes)**

Insurance Info

Patients will type in their info in each field.

☐ **Are you the primary subscriber?**	☐ **Subscriber name**	☐ **Subscriber birthdate**
☐ **Relationship to Subscriber**	☐ **Insurance company**	☐ **Group Number**
☐ **Policy/ID number**	☐ **Employer name**	☐ **Do you have secondary insurance?**

Referral Info

Patient will be able to mark their referral type, or choose "other" to be able to type in an option not on the list.

☐ **Another Patient**	☐ **Another Doctor**	☐ **Other**

Agreements

The agreements section will include a list of documents that your patients must open and accept before they will be able to submit their FastTrack forms. These documents cannot be edited/signed/initialed by the patient, so please edit your policy verbiage accordingly. Your patients will sign their acknowledgement of all forms at the end of the FastTrack process.

Default Agreements

You can choose to utilize our Default Financial Agreement and Privacy Policy, or you can add your own. Please review the defaults and mark your choice below. If you would like to use the Defaults as a guide with your own revisions, please copy the entirety of your edited document into the appropriate "use my own" verbiage field. To avoid transcription or interpretation errors, we will copy any submitted policies "as-is" into the FastTrack template.

☐ **Default Financial Agreement (displayed below)**

We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our Financial Policy, which we require that you read, agree to, and sign prior to any treatment. We are pleased to discuss our professional fees with you at any time. Your clear understanding of the Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility upon arrival at your first appointment.

ADULT PATIENTS
Adult patients are responsible for full payment at time of service.

MINORS ACCOMPANIED BY AN ADULT
The adult accompanying a minor, his/her parents or guardians, are responsible for full payment at time of service.

INSURANCE
We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.

Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time. If you are paid by the insurance company instead

of our practice, you then become responsible for the total account balance and payment would be expected immediately.

We ask that you sign this form and/or any other necessary documents that may be required by your insurance company.

DEDUCTIBLE/CO-PAYMENT
We may ask that you pay the deductible and co-payment, which is the estimated amount, not covered by your insurance company, by cash, check, credit card or Patient Financing at the time we provide the service to you.

MEDICARE/ MEDICAID/ CHAMPUS/ WORKER'S COMPENSATION
If you are covered by Medicare, Medicaid, CHAMPUS, Worker's Compensation or any other government sponsored program, please discuss your payment situation with our office staff prior to arriving at the office on the date of service.

DELINQUENT PAYMENTS
It is our policy to charge a finance fee for outstanding patient balances. In addition, all payments returned due to non-sufficient funds will be subject to a fee.

MISSED APPOINTMENTS
Unless cancelled in advance, our policy is to charge a fee for missed appointments. Please help us service you better by keeping scheduled appointments.

REFUND POLICY
You may discontinue treatment and request a refund at any time for any amount that you paid for treatment that you did not receive. Please contact your office if you'd like to request a refund.

By selecting Accept I confirm that I have read, understand and agree to the above terms and conditions. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part by my dental care payer.

☐ **Use my own Financial Agreement**

To use your own Financial Agreement, please paste the verbiage into this box.

☐ **No Financial Agreement**

☐ **Default Privacy Policy (displayed below)**

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize the release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I understand that I may withdraw or revoke my authorization at any time. I may revoke this authorization by notifying my practice in writing.

I understand that by signing this Consent form, I am giving my consent to disclose and discuss my protected health information to carry out treatment, payment activities and health care operations.

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to

perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.
☐ **Use my own Privacy Policy**
To use your own Financial Agreement, please paste the verbiage into this box.
☐ **No Privacy Policy**

Custom Policies/Agreements **You may also include any other policies that you would like your patients to accept before they submit their Patient FastTrack paperwork. Please include them below, along with the title that you would prefer for each. To avoid transcription or interpretation errors, we will copy any submitted policies "as-is" into the FastTrack template.**
Custom Policy 1 Title
Paste your custom Policy 1 verbiage here.
Custom Policy 2 Title
Paste your Custom Policy 2 verbiage here.
Custom Policy 3 Title
Paste your Custom Policy 3 verbiage here.
Custom Policy 4 Title
Paste your Custom Policy 4 verbiage here.
Custom Policy 5 Title
Paste your Custom Policy 5 verbiage here.

After accepting all policy documents, they will be asked to review their info, and agree to the following by signing their name. "I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge. I hereby give my consent to the dentist to perform an examination and diagnose my condition. ". This certification statement cannot be altered or removed.

Once the patient has signed they will submit the forms. The completed forms will appear in PDF format in the Notifications tab of your Dashboard, and can always be accessed in the Full Patient Record within Lighthouse. Congratulations! You've made it through the Patient FastTrack setup process! Please save these completed forms and email them to support@lighthousepmg.com. We should have your Patient FastTrack forms completed within 72 hours. We will send you an email at that time with a preview of the exact site that your patients will be directed to.

FAQ:

Why aren't there fields for the patient's name or cell phone number?

This information is automatically gathered when you enter it into the new appointment in your Practice Management Software. The patient's name will display on the first page of the Patient FastTrack form.

Why isn't there a field for the patient's social security number?

We have found that many patients prefer to not include such sensitive information in a form/website that comes from (to them) an unknown entity. However, this has been one of the most highly requested additional fields, and so it will likely be added in a future update. We do not yet have an ETA on the next update to the feature.