



Date _____
Received _____

Douglas M. Arendt DDS, MS
 Diplomate, American Board of Oral & Maxillofacial Pathology

PO Box 707 Oakton, VA 22124-0707
 (703) 281-5970 281-6970 (fax) cell (703) 303-1867
lightmic@aol.com www.lightmicron.com

PATIENT REFERRAL – CONSULT REQUEST

Requesting Doctor	Doctor		Patient	Last Name		First name		Initial		
	Address			Patients Address						
	City			State & Zip		City			State & Zip	
	Phone			Fax		Home Phone		Work Phone		
	NPI #			Email:		SSN		Age	DOB	
Pharmacy contact info				Physician contact info:						

CHIEF COMPLAINT - SYMPTOMS

Location of lesion(s) or process:		Bx Date:	
Date of last physical exam?		Date last lab (blood tests)	
History & Clinical Information			
Clinical Impression		Have X-rays been forwarded?	

MEDICAL INSURANCE (Please bring your card or fill in below)

1. Lightmic Consulting requires credit card info as a security deposit
2. Your credit card will not be billed until after we receive the **EOB** from your insurance company and contact you, giving you payment option(s) if needed.

Patient:		Card Holder		Credit Card: (MC or Visa only)	
Credit Card #		Expiration Date		Billing Zip Code	
Insurance Plan Name		Name of Subscriber		Relation to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	
Insurance Plan Phone #	Subscriber ID #		Group or Policy #		

Private Insurance Authorization for assignment of Benefits / Information Release

I, the undersigned authorize payment of medical benefits to Lightmic Consulting, LLC for any services furnished to me by the clinician. **Lightmic Consulting, LLC will courtesy submit to your insurance company.** I understand that I am financially responsible for the amount not covered by my contract. I also. authorize you to release to my insurance company or agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Patient – (Parent or guardian signature if child is under 18 years old)		Date
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