

**DENTAL CLINIC – PATIENT MEDICAL & DENTAL INFORMATION**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Patient ID \_\_\_\_\_

**MEDICAL INFORMATION**

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Are you now under the care of a physician? If so, Physician Name _____ Phone: _____	<input type="checkbox"/>	<input type="checkbox"/>	Active Tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>
Females: Could you be or are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	Persistent Cough greater than a three (3) weeks duration or Cough that produces blood?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use controlled substances (drugs)?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past five (5) years?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use tobacco (smoking, snuff, chew, bidis)? If so, how long? _____	<input type="checkbox"/>	<input type="checkbox"/>	Are you taking or have you recently taken any prescription or over-the-counter medicine(s)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you used tobacco in the past?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had an allergic reaction to local anesthetic?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please <u>list all medicines</u> including aspirin, vitamins, natural or herbal preparations and/or diet supplements:</b>		
Are you taking or scheduled to begin taking either of the medications Alendronate (Fosamax®) or Risedronate (Actonel®) for Osteoporosis or Paget’s Disease?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget’s Disease, multiple myeloma or metastatic cancer?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Date treatment began: _____			<b>List all <u>DRUG ALLERGIES</u> (Penicillin, latex, codeine)</b>		
			_____		
			_____		

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Anemia .....	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia .....	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse .....	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Use .....	<input type="checkbox"/>	<input type="checkbox"/>	Asthma .....	<input type="checkbox"/>	<input type="checkbox"/>	Organ Transplant .....	<input type="checkbox"/>	<input type="checkbox"/>
Aneurysm .....	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	Pancreatitis .....	<input type="checkbox"/>	<input type="checkbox"/>
Angina/Chest Pain .....	<input type="checkbox"/>	<input type="checkbox"/>	Cancer .....	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia .....	<input type="checkbox"/>	<input type="checkbox"/>
GERD/Chronic Heartburn .....	<input type="checkbox"/>	<input type="checkbox"/>	Coumadin .....	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problem .....	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker .....	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever .....	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve .....	<input type="checkbox"/>	<input type="checkbox"/>	STD/Venereal Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	Skin Problem/Rash .....	<input type="checkbox"/>	<input type="checkbox"/>
Previous infective Endocarditis .....	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intestinal Prob. ....	<input type="checkbox"/>	<input type="checkbox"/>
Damaged Valves in transplanted Heart .....	<input type="checkbox"/>	<input type="checkbox"/>	Emotional Problems .....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke .....	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema .....	<input type="checkbox"/>	<input type="checkbox"/>	Surgery .....	<input type="checkbox"/>	<input type="checkbox"/>
Unrepaired Cyanotic CHD .....	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizure .....	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease .....	<input type="checkbox"/>	<input type="checkbox"/>
Repaired (completely) in last six (6) months .....	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia .....	<input type="checkbox"/>	<input type="checkbox"/>	Tumor or Growth .....	<input type="checkbox"/>	<input type="checkbox"/>
Repaired CHD with residual defects .....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A, B, or C .....	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma .....	<input type="checkbox"/>	<input type="checkbox"/>
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?			Herpes/Cold Sore .....	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>
Name of physician or dentist making this recommendation _____ Phone: _____			High Blood Pressure .....	<input type="checkbox"/>	<input type="checkbox"/>	Hospitalization .....	<input type="checkbox"/>	<input type="checkbox"/>
			HIV/AIDS .....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems .....	<input type="checkbox"/>	<input type="checkbox"/>
			Heart Murmur .....	<input type="checkbox"/>	<input type="checkbox"/>	Liver Problems .....	<input type="checkbox"/>	<input type="checkbox"/>

**DENTAL INFORMATION**

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Do your gums bleed when you brush/floss?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or neck pain?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure?	<input type="checkbox"/>	<input type="checkbox"/>	Are you currently experiencing dental pain or discomfort?	<input type="checkbox"/>	<input type="checkbox"/>
Does food or floss catch between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have sores or ulcers in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry?	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam: _____		
Have you had any periodontal (gum) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	What was done at that time: _____		
Have you ever had orthodontic (braces) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	Date of last dental x-rays: _____		
What is the reason for your dental visit today? _____					
How do you feel about your smile? _____					

To the best of my knowledge the above information is true and correct. I understand this information will be kept confidential. I will inform the doctor of any changes in my health and medical condition, or if my medicines change.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Staff Initials: \_\_\_\_\_

# PATIENT REGISTRATION FORM

5000 Blackmore Road; Casper, WY 82609

<b>Last Name</b>		<b>First Name</b>		<b>Middle Name</b>	
<b>Social Security Number</b>		<b>Date of birth (mm/dd/yyyy)</b>		<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	
				<b>Who is your Medical Provider?</b>	
<b>Mailing Address</b>		<b>City</b>		<b>State</b>	
				<b>Zip</b>	
<b>Home phone number:</b>		<b>Cell phone number:</b>		<b>What is your marital status?</b> <input type="checkbox"/> Divorced <input type="checkbox"/> Married	
				<input type="checkbox"/> Single <input type="checkbox"/> Domestic partner <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	
<b>Employer Name:</b>		<b>Employment Status?</b> <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Unemployed			
		<input type="checkbox"/> Retired <input type="checkbox"/> Disabled			
<b>Employer Address:</b>		<b>Preferred Language with Clinician?</b>		<b>Do you need an Interpreter?</b>	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Employer Phone Number:</b>		<b>Email Address:</b>			
<b>Student Status</b>		<b>Preferred Pharmacy:</b>			
<input type="checkbox"/> Student Full Time <input type="checkbox"/> Student Part Time <input type="checkbox"/> Not Student					
<b>Please select one of the following from the ethnicity listing:</b>				<input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic	
<b>Please check one of the following from the race listing:</b> <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> White					
<input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> More than One Race					
<b>How did you hear about our clinic?</b> <input type="checkbox"/> CHCCW Employee <input type="checkbox"/> CHCCW Website <input type="checkbox"/> Billboard <input type="checkbox"/> Business/Agency <input type="checkbox"/> Friend/Family					
<input type="checkbox"/> Fair/Festival/Event <input type="checkbox"/> Hospital/Clinic <input type="checkbox"/> Internet <input type="checkbox"/> Newspaper/Magazine <input type="checkbox"/> School <input type="checkbox"/> Patient <input type="checkbox"/> TV <input type="checkbox"/> Radio					
<b>EMERGENCY CONTACT INFORMATION</b>					
<b>Emergency contact:</b> Spouse, Friend, Legal Guardian or Parent (if patient is a minor)			<b>Relationship to patient:</b>		<b>Phone number:</b>
<b>GUARANTOR INFORMATION</b>					
<b>Last Name</b>		<b>First Name</b>		<b>Middle Name</b>	
<b>Street address</b>		<b>City</b>		<b>State</b>	
				<b>Zip</b>	
<b>Date of birth (mm/dd/yyyy)</b>		<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female		<b>Phone Number</b>	
				<b>Patients Relation to Guarantor</b>	
<b>INSURANCE</b>					
<b>Insurance company</b>			<b>Start date</b>		
<b>Employer</b>			<b>ID #</b>		<b>Group #</b>
<b>Policy holder's first and last name</b>			<b>Policy holder's date of birth</b>		<b>Policy holder's social security #</b>
<b>HEALTH CENTER FUNDING INFORMATION</b>					
In order to continue the variety of services that we offer here at CHCCW and to continue to receive grant funding, we are required to collect the following information on every person that visits our facility. This information is reported as a cumulative number and not reported on individual patients.					
<b>How many people in your family?</b> (yourself, spouse and minor children under 18 years)			<b>What is your household annual income?</b> (income of the persons listed in your family if they are working)		
<b>Have you done agriculturally related work in the last 3 years?</b> <input type="checkbox"/> Migrant farm work <input type="checkbox"/> Seasonal farm work <input type="checkbox"/> No			<b>Are you a veteran?</b>		<b>Are you homeless?</b> <input type="checkbox"/> Shelter <input type="checkbox"/> Street
			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Transitional Housing <input type="checkbox"/> Other <input type="checkbox"/> No

# PATIENT REGISTRATION FORM

5000 Blackmore Road; Casper, WY 82609

**CONSENT TO TREATMENT:**

I hereby request and consent to diagnostic procedures, tests, and medical treatment, family planning, birth control methods, and immunizations as deemed advisable by the professional staff of Community Health Centers of Central Wyoming (CHCCW). I am aware that a Physician or a Nurse Practitioner may provide the medical care. Services will be in my best interest, or the best interest of my child or legal charge. I understand that this consent to treatment will be in effect as long as I am seen at any of the Community Health Centers of Central Wyoming clinic sites. I may cancel this consent in writing.

Signed: X \_\_\_\_\_  
Patient Signature/Parent/Legal Guardian Signature (Please circle one) Date: \_\_\_\_\_

**Please print full name and relationship to patient if the patient cannot sign this document.**

\_\_\_\_\_  
Full name (print) Relationship

**AUTHORIZATION FOR MEDICAL RECORDS RELEASE/REFERRAL AND ASSIGNMENT OF BENEFITS:**

I authorize CHCCW to release medical/social information to persons or agencies directly concerned with and engaged in carrying out a treatment plan for the patient. Also CHCCW may use and release any part of my medical records necessary to the process of billing third party payors for services rendered on my behalf. I clearly understand that all my information will be kept confidential. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and complaint resolution.

I authorize payment directly to Community Health Centers of Central Wyoming for all medical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. Overpayments on any Community Health Centers of Central Wyoming account may be applied to my patient balance. A photocopy of this authorization shall be considered as effective and as valid as the original.

Signed: X \_\_\_\_\_  
Patient Signature/Parent/Legal Guardian Signature (Please circle one) Date: \_\_\_\_\_

**Please print full name and relationship to patient if the patient cannot sign this document.**

\_\_\_\_\_  
Full name (print) Relationship

**PROTECTED HEALTH INFORMATION DESIGNEE:**

I understand that the individuals identified below will be treated by Community Health Centers of Central Wyoming as individuals involved directly in my care or my child's care, and as such CHCCW will be allowed to release the patient's personal health information to these individuals for the purpose of treatment including making appointments, bringing a minor child for medical treatment, and all other functions normally associated with individual patient care, payment, and health care operations.

Name of Designee: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Name of Designee: \_\_\_\_\_ Relationship of Patient: \_\_\_\_\_

I decline to provide a protected health information designee contact for myself or my child at this time.  
Patient Signature/Parent/Legal Guardian \_\_\_\_\_ Date: \_\_\_\_\_



## FINANCIAL AND APPOINTMENT POLICY

Thank you for choosing Community Health Center of Central Wyoming (CHCCW) Dental Clinic as your dental care provider. We strive to offer quality and affordable dental services provided by qualified professionals. It is important that you understand your financial and appointment responsibilities, recommended treatment plan, the costs associated, and that some dental procedures may require referral to another dentist or specialist.

**Treatment Plan:** When you are scheduled for a Comprehensive Exam our dentist will perform an evaluation of your dental and oral health needs and develop a treatment plan that will address those needs. The dentist has authorized the dental staff to perform some services required to provide the diagnosis and treatment plan. The dental clinic requires that you see the hygienist according to your prescribed maintenance schedule in order to continue to be treated by the dentist. Repeated visits may be required for completion of this treatment plan. Your dentist will discuss the details of your treatment plan with you and give you a copy upon request.

**Dental or Specialist Referral:** Your treatment plan may require services that cannot be provided at the CHCCW Dental Clinic. In this case, you will be referred to another dentist or specialist for completion of your treatment plan. Payment arrangements must be made with the dentist/specialist office prior to your first visit. Sliding fees will not apply to outside providers.

**Payment Expectations:** The CHCCW Dental Clinic provides many options for dental patients to minimize the financial barriers to healthy and complete dental care. As a courtesy the office staff will file to all insurances, including Medicaid. However, you will be expected to pay your estimated co-insurance at the time of service. If your insurance or Medicaid does not pay for part or all of the services, you are responsible for the billed amount. We realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in management of your account. If you show up without payment, your appointment will be rescheduled. True emergencies will be handled on a case-by-case basis.

**Dental Insurance and Medicaid:** Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. You understand that all charges are ultimately your responsibility even if insurance does not pay. Please be aware that some, and perhaps all, of the services provided may not be covered services and not considered reasonable and customary under the terms of your insurance policy. If you do not have insurance, CHCCW will help find an available financial assistant program. If none is found, CHCCW offers the sliding fee discount for those who qualify, please ask the receptionist about the requirements. We do everything possible to keep our services affordable.

**Emergencies:** The CHCCW Dental Clinic will provide emergency dental services whenever possible. However, referral to another Dentist, Specialty, or Primary Care provider may be necessary to accommodate your emergent needs, based on the severity of the emergency. When there is not availability on our schedule, we will keep a waiting list for those emergencies that want to schedule with our clinic. Or, we will schedule your for the next available time, which could be several days.

**Lab Charges:** Some dental procedures require the use of an outside Lab for services such as dentures, bridges, crowns, etc. You must pay in advance for Lab services. If you are on a sliding scale, the charges for Laboratory cases are discounted differently than the normal discounted percent for your sliding scale.

**Scheduling, Cancelling and No-Showing for Appointments:** The CHCCW Dental Clinic will make every effort to schedule your appointments according to your recommended treatment plan. Check-in is twenty (20) minutes prior to your scheduled appointment time. An appointment must be cancelled at least two (2) hours prior to the time of the appointment or will be considered a "No Show". Patients who no-show for dental treatments will not be seen until they pay a twenty-five dollar (\$25.00) late fee, which will not be billed to insurance, payment is required before scheduling next appointment. Patients that arrive ten (10) minutes late for scheduled appointment will be asked to wait in the lobby while the receptionist checks with the provider to determine if the patient can be seen at that time.

**CHCCW HIPAA / Patient's and Provider's Rights and Responsibilities.** The Dental Clinic provides copies of these policies. Patient acknowledges they have read and understand these policies.

***I HAVE READ*** the CHCCW Dental Clinic Financial and Appointment Policy and understand the services provided and my responsibilities as a dental clinic patient. I authorize the dentist and the dental staff to provide services to me.

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Signature of Patient or Guardian \_\_\_\_\_ Date \_\_\_\_\_

## **UNATTENDED CHILD POLICY ACKNOWLEDGMENT**

*Your cooperation will be needed to help us provide the best possible dental care to your family. Please read our policies below and initial next to each statement.*

\_\_\_\_\_ I understand and am aware it is a courtesy to allow others to be present during treatment and only one (1) parent or authorized adult (i.e. guardian, power of attorney, spouse, etc.) will be allowed into the treatment area, there will be no siblings.

\_\_\_\_\_ I understand and am aware that clinic staff will not be responsible for unattended children in the waiting area and it is my responsibility to find appropriate supervision/care for my children if I choose to be present in the treatment area.

\_\_\_\_\_ I understand and am aware children may not be left in the waiting area while I am being treated and I must reschedule my appointment if I do not have appropriate supervision/care for the children.

\_\_\_\_\_ I understand and am aware that in order to respect patient and staff privacy, I will remain seated outside of the operatory at all times and will avoid wandering through the patient treatment area.

\_\_\_\_\_ I understand and am aware cell phone conversations are prohibited while in the treatment area. If my conversation or actions are loud and/or disruptive, I will be asked to return to the waiting area.

\_\_\_\_\_ I understand and am aware it is prohibited to take photographs while in the treatment area.

\_\_\_\_\_ I understand and am aware to refrain from conversation with the doctor and dental assistant while they are performing treatment. If I have any questions or concerns, I will try to address them at the beginning or end of the treatment encounter.

\_\_\_\_\_ I understand and am aware that should the patient become uncooperative during dental procedures with movement of the head, arms, and/or legs, dental treatment cannot be safely provided. During such disruptive behavior, it may be necessary for the assistant(s) and/or dentist to hold the patients hands, stabilize the head and/or control leg movements for their safety. I also understand that it is best to refrain from attempting to help control behavior and to stay seated.

\_\_\_\_\_ I understand and am aware in order to provide the delivery or safe dental care a referral to a Pedodontist may be suggested and appropriate contact information will be provided.

***By signing below I confirm that I have read and understand this form or it was read and explained to me and all my questions have been answered to my satisfaction.***

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Patient/Guardian Signature

Date