



**ADULT DENTAL
COMMUNITY HEALTH CENTER OF CENTRAL MISSOURI
REGISTRATION FORM**



PATIENT INFORMATION					
Last Name:		First Name:		MI:	Birth Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Birth date:		Social Security Number:			
Mailing Address:			City, State:	Zip Code:	County:
Home Phone: () ()		Cell Phone: () ()		Email Address:	
Race (Circle One) White/ Black or African American/ American Indian or Alaska Native/ Asian/ Hawaiian or Pacific Islander/ Multi-racial/ Other:				Ethnicity: Hispanic or Latino origin? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:			Interpreter Required? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you a Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No
Primary Care Physician:			Primary Dental Provider:		

GUARANTOR INFORMATION				
Name of Responsible Party:		Birth date: / /	Relationship of Responsible Party to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Spouse <input type="checkbox"/> Caregiver <input type="checkbox"/> Other:	
Address (if different than patient):			City, State:	Zip Code:
Home Phone: () ()		Cell Phone: () ()		Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No

EMERGENCY CONTACT				
Name of local friend or relative:		Relationship to Patient:	Home Phone: () ()	Cell Phone: () ()

INSURANCE			
(Please provide complete insurance information regardless of type of service utilizing. Provide all cards to the front desk.)			
Primary <u>Medical</u> Insurance: <input type="checkbox"/> Uninsured <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Private/Commercial:			
Subscriber Name:	Date of Birth: / /	Policy/ID Number:	
Secondary <u>Medical</u> Insurance: <input type="checkbox"/> Uninsured <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Private/Commercial:			
Subscriber Name:	Date of Birth: / /	Policy/ID Number:	
Primary <u>Dental</u> Insurance: <input type="checkbox"/> Uninsured <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Private/Commercial:			
Subscriber Name:	Date of Birth: / /	Policy/ID Number:	
Secondary <u>Dental</u> Insurance: <input type="checkbox"/> Uninsured <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Private/Commercial:			
Subscriber Name:	Date of Birth: / /	Policy/ID Number:	

AS A FEDERAL FACILITY WE ARE REQUIRED TO ASK THE FOLLOWING QUESTIONS

ANNUAL INCOME - Locate your family size and circle the income range in that row that best fits your household.					
Family Size					
1	\$0 - \$13590	\$13591-\$20385	\$20386-\$23783	\$23784-\$27180	\$27181 and up
2	\$0 - \$18310	\$18311-\$27465	\$27466-\$32043	\$32044-\$36620	\$36621 and up
3	\$0 - \$23030	\$23031-\$34545	\$34546-\$40303	\$40304-\$46060	\$46061 and up
4	\$0 - \$27750	\$27751-\$41625	\$41626-\$48563	\$48564-\$55500	\$55500 and up
5	\$0 - \$32470	\$32471-\$48705	\$48706-\$56823	\$56824-\$64940	\$64941 and up
6	\$0 - \$37190	\$37191-\$55785	\$55786-\$65083	\$65084-\$74380	\$74381 and up
7	\$0 - \$41910	\$41911-\$62865	\$62866-\$73343	\$73344-\$83820	\$83821 and up
8	\$0 - \$46630	\$46631-\$69945	\$69946-\$81603	\$81604-\$93260	\$93261 and up

For patients 12 and older only

GENDER IDENTITY – What is your internal sense of your gender? Do you think of yourself as:
 Male Female Male Transgender (Female to Male) Female Transgender (Male to Female) Other Refuse to Report

SEXUAL ORIENTATION – How do you identify your physical and emotional attraction to others? Do you think of yourself as:
 Straight (not gay or lesbian) Gay or lesbian Bisexual Something Else Don't Know Refuse to Report

By signing below I agree that the above information is accurate and true to the best of my knowledge:

Patient/Guardian Signature:	Date:
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GENERAL POLICIES AND CONSENTS

APPOINTMENT TIMES

It is important you show up to all appointments on time. All **new patients** are required to check in at least 30 minutes prior to their appointment. All **established patients** must check in at least 15 minutes prior to their appointment. This will allow time to complete all necessary paperwork and allows the staff to get the patient in the exam room by the actual appointment time. This will allow for a much smoother and timely visit. Failure to check in timely will result in the need to be rescheduled.

All minors (children age 17 and under) must be accompanied by a parent or legal guardian at all appointments.

MISSED APPOINTMENTS

The Community Health Center of Central Missouri is dedicated to serving the members of our community. Our missed appointment policy is strictly enforced as we truly desire to provide timely, quality care to our patients, but this becomes difficult when patients miss scheduled appointments. A missed appointment includes any appointment for which the patient does not present to the designated clinic/location, an appointment not cancelled/rescheduled at least 24 hours in advance and showing up for an appointment late necessitating a reschedule.

We value family here and understand that it is often easiest to schedule all appointments on the same day. If you miss appointments scheduled for multiple family members, each family member will only be given appointments on different days in the future. If a child is requiring treatment, it is important to keep these appointments so they can receive necessary care. Failure to bring a child for treatment is considered neglect. CHCCMO is required to report suspected cases of neglect.

FAMILY PRACTICE/PEDIATRICS/OBGYN/MENTAL HEALTH

In the event of excessive missed appointments, CHCCMO has the right to grant care on an emergency or walk in basis only.

DENTAL

After your initial missed appointment, any future appointments will be cancelled and rescheduled one at a time. Any patient who accumulates 2 missed appointments within a 6 month period will not be allowed to schedule an appointment for a period of 6 months. During that time that patient can seek care via "same day appointments" only; you will need to call the office the day you wish to seek care to see if any openings are available so that we can assist you.

If a patient is reinstated to be seen after their 6 month period or scheduled for a same day visit and accumulates another missed appointment, they will then be unable to schedule an appointment for 1 year and be seen only for emergent dental needs under our limited program.

FINANCIAL AGREEMENT

Payment is expected at time of service. If insurance has been provided, you are hereby authorizing CHCCMO to release health information necessary to process your claims. In addition, you are also authorizing payment for insurance benefits to be paid directly to CHCCMO. You understand that you are responsible for any copays, coinsurance, deductibles, or non-covered services.

CONSENT TO TREAT

By signing below, I consent to receiving care considered advisable from a CHCCMO provider. Such treatment may include, but is not limited to, examination and basic diagnostic testing. I attest that I have the legal authority to make health care decisions and act on behalf of the patient if the patient is a minor or otherwise incapacitated.

PERSONAL VALUABLES

I recognize that CHCCMO is not responsible for any personal property brought onto CHCCMO's premises.

I have read and fully understand the policies and consents included on this form.

PATIENT, PARENT OR LEGAL GUARDIAN SIGNATURE

DATE

HEALTH INFORMATION EXCHANGE CONSENT

The Health Information Exchange (HIE) allows multiple healthcare provider to link by electronic medical records. When going to an outside healthcare provider, Community Health Center of Central Missouri may be able to share and/or obtain my medical records through the HIE. All providers must have sufficient personal information to prove they have a treatment relationship with you as a patient before the HIE will allow access to information. An HIE is important because sharing information improves care.

Community Health Center of Central Missouri Partners with the following HIEs:

- Tiger Institute Health Information Alliance
- Carequality/SureScripts

You can choose to if you want to participate in the HIE. The care you receive from providers at CHCCMO is not dependent on whether you choose to participate in the HIE. With this form you may choose from 2 options:

Option 1 - Opt In

I hereby authorize Community Health Center of Central Missouri to RELEASE and OBTAIN all of my medical records and medical information, including records which relate to any physical or mental condition, psychological condition, psychiatric evaluation and treatment, psychotherapy, counseling, drug addition, infection status, HIV/AIDs, genetic testing, or treatment for drug or alcohol abuse, even though such information is protected by federal law, to the above HIEs.

The purpose of this disclosure is for healthcare treatment purposes, change in providers and continuity of healthcare. I specifically authorize the release of my medical information to and from the above HIEs in an electronic format.

Option 2 - Opt Out

By signing this form you acknowledge that you understand the statements below:

- I understand that I am signing this form because I do not want my health records shared with my providers and health care team members through the HIEs listed above.
- I understand that this opt-out form only applies to the HIEs listed above that Community Health Center of Central Missouri participates in and does NOT cover or affect my opting out of any other HIE.
- I may choose to join the HIEs that Community Health Center of Central Missouri participates in at any time by signing an HIE Request to Opt-In form.
- I understand that by opting out of the above HIEs, my providers will not have immediate access to critical information about my health accessible through these HIEs. This may impact my provider’s ability to see a complete picture of my health which could limit their ability to make the best possible decisions about my care.
- This request can take up to 3-5 business days to take effect.

• **Opt In – I choose to Opt-in to the HIE; I give consent for CHCCMO to share all health information through the HIE.**

This authorization is valid until revoked by me in writing, and it will be effective the date received.

• **Opt Out – I am choosing to Opt-out of the HIE; I am requesting none of my health information be shared through the HIE.**

PATIENT, PARENT, OR LEGAL GUARDIAN SIGNATURE

RELATIONSHIP TO PATIENT

DATE

WITNESSED BY

DATE

HIPAA AGREEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly or indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I understand I can request a copy of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

Please list below any individuals you would like CHCCMO to be able to talk to about your (or your dependent’s) care, treatment, payment, or appointments. For minors, please ensure all legal custodial guardians are listed. Anyone who is not listed on this form will be unable to access any information about your healthcare. CHCCMO will ask these persons to identify themselves before sharing any PHI.

I, _____, give my permission for the Community Health Center staff to discuss all health information with:

Name	Relationship to patient

PRINT NAME

RELATIONSHIP TO PATIENT

SIGNATURE OF PATIENT, PARENT, OR LEGAL GUARDIAN

DATE

INFORMED CONSENT FOR GENERAL DENTAL PROCEDURES

You have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and risks of the procedure, alternative treatments, or the option of no treatment.

Ask: Do I understand the procedure, do I have another choice?

When you consent you are acknowledging your willingness to accept known risks and complications.

Ask: What will happen if I don't do this procedure?

Heart conditions, pregnancy, stroke, joint replacements, and other medical conditions can create a risk of complications. Please report all health conditions and medications accurately to reduce chances of complications.

Ask: Have I told the dentist all my medical problems?

General dental procedures include examination, dental prophylaxis, fluoride treatment, xrays, restorations, periodontal therapy, pulp therapy, stainless steel crowns, extractions, crowns, bridges, endodontic therapy, removable appliances like dentures and partial dentures, minor surgical procedures like fibrotomy, frenectomy.

There are no guarantees of ultimate outcomes of any procedure, but the risks and benefits have been explained.

Ask: Why am I signing a general consent form?

This form is a general explanation of procedures offered, and your agreement to these procedures. Some procedures needed added consent like extraction of teeth and root canals.

INFORMED CONSENT FOR LOCAL ANESTHETICS

This consent form is designed to make you aware of the risks involved with local anesthesia which is commonly used prior to dental treatment. The risks include, but are not limited to:

- Dizziness, nausea, vomiting, accelerated heart rate, slow heart rate, allergic reaction.
- Stiff or sore jaw muscles at injection site.
- Prolonged numbness, and risk of biting lip, tongue, or cheek, causing injury.
- Injury to the nerves causing pain, numbness, tingling, especially in chin, lip, cheek, gums, or tongue. Usually lasts 24 hours or less.
- Breaking needle in mouth requires removal by a specialist.
- Large bruise at injection site causing swelling, stiff muscles, opening and closing stiffness.

I have read and fully understand this consent form. I understand that I should not sign this form if all items, including all my questions have not been explained or answered to my satisfaction or if I do not understand any of the words contained in this form.

PATIENT, PARENT, OR LEGAL GUARDIAN SIGNATURE

RELATIONSHIP TO PATIENT

DATE

WITNESS SIGNATURE

DATE

Patient Name: _____

DOB: _____

ADULT DENTAL HISTORY

Welcome to the Community Health Center – Tell Us About Yourself

Do you have a personal physician? Yes No

Physician's Name: _____

Physician's Phone: _____ Date of last visit: _____

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain: _____

Do you have a Guardian? Yes No If yes, who? _____

Do you use tobacco in any form? Yes No

What form of tobacco? _____ Are you interested in quitting? Yes No

Have you had any metal rods, pins or implants placed? Yes No

Are you taking any medications? Yes No

Please list each one: _____

Have you ever had any surgical procedures? Yes No

Please list each one: _____

Medical History

- | Yes | No | Conditions |
|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | ADD/ADHD |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol Abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina Pectoris |
| <input type="checkbox"/> | <input type="checkbox"/> | Anxiety |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial Heart Valve |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Autism |
| <input type="checkbox"/> | <input type="checkbox"/> | Bisphosphonate Therapy |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Transfusion |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Chemotherapy |
| <input type="checkbox"/> | <input type="checkbox"/> | Cognitive Disability |
| <input type="checkbox"/> | <input type="checkbox"/> | Congenital Heart Defect |
| <input type="checkbox"/> | <input type="checkbox"/> | COPD |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty Breathing |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug Abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting Spells |

- | Yes | No | Conditions |
|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Fever Blisters |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis C |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacement |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Low Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse |
| <input type="checkbox"/> | <input type="checkbox"/> | Pace Maker |
| <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Seasonal Allergies |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Sexually Transmitted Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Shingles |

- | Yes | No | Conditions |
|--------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcers |
| <input type="checkbox"/> | <input type="checkbox"/> | Infective Endocarditis |
| Yes | No | Allergies |
| <input type="checkbox"/> | <input type="checkbox"/> | Aspirin |
| <input type="checkbox"/> | <input type="checkbox"/> | Codeine |
| <input type="checkbox"/> | <input type="checkbox"/> | Dental Anesthetics |
| <input type="checkbox"/> | <input type="checkbox"/> | Erythromycin |
| <input type="checkbox"/> | <input type="checkbox"/> | Jewelry |
| <input type="checkbox"/> | <input type="checkbox"/> | Latex |
| <input type="checkbox"/> | <input type="checkbox"/> | Metals |
| <input type="checkbox"/> | <input type="checkbox"/> | Penicillin |
| <input type="checkbox"/> | <input type="checkbox"/> | Tetracycline |
| <input type="checkbox"/> | | Other: _____ |

- | Yes | No | For Females Only |
|--------------------------|--------------------------|-------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Are you taking Birth Control Pills? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant? |
| | | If so, # of Weeks _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you nursing? |

Patient Name: _____

DOB: _____

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information the dentist should be aware of that was not discussed above:

CHIEF DENTAL COMPLAINT:
PLEASE LIST

ARE YOU CURRENTLY HAVING PROBLEMS WITH DENTAL PAIN OR PAIN
MANAGEMENT..... YES NO

IF SO – HOW SEVERE IS IT ON A SCALE OF 1-10 WITH 10 BEING WORST..... 1 2 3 4 5 6 7 8 9 10

I certify that I have read the above information and it is true to the best of my knowledge. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Patient/Guardian Signature

Date

Doctor's Signature

Date