



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:	
Home Phone: ( )		Cell Phone: ( )		Email Address:	
Race (Circle One) White/ Black or African American/ Multi-racial/ American Indian or Alaska Native Asian/ Asian Indian/ Hawaiian or Pacific Islander/ Other Pacific Islander not Hawaiian Chinese/ Filipino/ Korean/ Vietnamese/ Other Asian/ Guamanian or Chamorro Samoan/ Other				Are you Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please further specify (circle one): Mexican/Mexican American/ Chicano/ Puerto Rican Cuban/ Other Hispanic or Latino Origin	
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 <b>Medical</b> 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 <b>Medical</b> 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 <b>Dental</b> 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 <b>Dental</b> 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					
<b>ANNUAL INCOME - Locate your family size and circle the income range in that row that best fits your household.</b>					
Although we are not a free clinic, we offer discounted (nominal) fees to eligible patients. Providing the below can help us determine eligibility for such programs.					
Family Size	<input type="checkbox"/> Refuse to report - please initial _____				
1	\$0 - \$15060	\$15061-\$22590	\$22591-\$26355	\$26356-\$30120	\$30121 and up
2	\$0 - \$20440	\$20441-\$30660	\$30661-\$35770	\$35771-\$40880	\$40881 and up
3	\$0 - \$25820	\$25821-\$38730	\$38731-\$45185	\$45186-\$51640	\$51641 and up
4	\$0 - \$31200	\$31201-\$46800	\$46801-\$54600	\$54601-\$62400	\$62401 and up
5	\$0 - \$36580	\$36581-\$54870	\$54871-\$64015	\$64016-\$73160	\$73161 and up
6	\$0 - \$41960	\$41961-\$62940	\$62941-\$73430	\$73431-\$83920	\$83921 and up
7	\$0 - \$47340	\$47341-\$71010	\$71011-\$82845	\$82846-\$94680	\$94681 and up
8	\$0 - \$52720	\$52721-\$79080	\$79081-\$92260	\$92261-\$105440	\$105441 and up
<b>For patients 12 and older only</b>					
<b>GENDER IDENTITY – What is your internal sense of your gender? Do you think of yourself as:</b>					
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Male Transgender (Female to Male) <input type="checkbox"/> Female Transgender (Male to Female) <input type="checkbox"/> Other <input type="checkbox"/> Refuse to Report					
<b>SEXUAL ORIENTATION – How do you identify your physical and emotional attraction to others? Do you think of yourself as:</b>					
<input type="checkbox"/> Straight (not gay or lesbian) <input type="checkbox"/> Gay or lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Something Else <input type="checkbox"/> Don't Know <input type="checkbox"/> Refuse to Report					
<b>By signing below I agree that the above information is accurate and true to the best of my knowledge:</b>					
Patient/Guardian Signature:				Date:	

## 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 may 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

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

I understand my provider will recommend a treatment plan aimed at improving my health and wellbeing. 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 understand that noncompliance with recommended treatment could result in worsening of my condition or an increased risk of complications. 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.

### PATIENT CONDUCT

CHCCMO is committed to providing a safe environment for all patients, employees and visitors. Violent, aggressive, or verbally abusive behavior will not be tolerated and may result in removal from the premises.

### 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.

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PATIENT, PARENT, OR LEGAL GUARDIAN SIGNATURE

RELATIONSHIP TO PATIENT

DATE

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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**

- Abnormal Bleeding
- ADD/ADHD
- Alcohol Abuse
- Anemia
- Angina Pectoris
- Anxiety
- Arthritis
- Artificial Heart Valve
- Asthma
- Autism
- Bisphosphonate Therapy
- Blood Transfusion
- Cancer
- Chemotherapy
- Cognitive Disability
- Congenital Heart Defect
- COPD
- Depression
- Diabetes
- Difficulty Breathing
- Drug Abuse
- Emphysema
- Fainting Spells

Yes No **Conditions**

- Fever Blisters
- Frequent Headaches
- Glaucoma
- HIV/AIDS
- Heart Attack
- Heart Murmur
- Heart Surgery
- Hemophilia
- Hepatitis C
- High Blood Pressure
- Joint Replacement
- Kidney Problems
- Liver Disease
- Low Blood Pressure
- Mitral Valve Prolapse
- Pace Maker
- Psychiatric Problems
- Radiation Therapy
- Rheumatic Fever
- Seasonal Allergies
- Seizures
- Sexually Transmitted Disease
- Shingles

Yes No **Conditions**

- Sickle Cell Disease
- Sinus Problems
- Stroke
- Thyroid Problems
- Ulcers
- Infective Endocarditis

Yes No **Allergies**

- Aspirin
- Codeine
- Dental Anesthetics
- Erythromycin
- Jewelry
- Latex
- Metals
- Penicillin
- Tetracycline
- Other: \_\_\_\_\_

Yes No **For Females Only**

- Are you taking Birth Control Pills?
- Are you pregnant?  
If so, # of Weeks \_\_\_\_\_
- 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:

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**CHIEF DENTAL COMPLAINT:**  
PLEASE LIST

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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