# Dental History Adult & Child

To meet all your healthcare needs, please fill out this form completely. This is a confidential record of your medical history.

Name: (Last) ______________________ (First) _____________________ (MI) ______ Date of Birth: ____________ Age: _____

Do you have an Optometrist (Eye Doctor): ___ YES ___ NO
Do you have a Therapist/Counselor: ___ YES ___ NO
Do you have a Primary Medical Provider (Family Doctor): ___ YES ___NO

1. PAST MEDICAL HISTORY: Have you ever had the following: ____ Patient denies any illnesses

| Condition | Date | Condition | Date | Condition | Date |
|---|---|---|---|---|---|
| Anemia | | Asthma | | Epilepsy | |
| Diabetes | | Rheumatic Fever | | Hypertension | |
| Heart Disease | | Kidney Disease | | Hepatitis | |
| Bone Disease | | HIV | | Other | |
| | | | | | |

2. PAST SURGICAL HISTORY: Have you ever had the following: ____ Patient denies any surgeries

| Surgery | Date | Surgery | Date | Surgery | Date |
|---|---|---|---|---|---|
| Pacemaker | | Joint Replacement | | Oral Surgery | |
| Bone Fracture | | Back Surgery | | Other | |

3. MEDICATIONS: Please list ALL medications you are currently taking. ____ Patient denies any medications

| Name of Medication | Dosage (mg) | How Often |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

4. ALLERGIES: Please list ALL allergies (food, drugs, and environment) ____ Patient denies any allergies

| Allergen | Reaction |
|---|---|
| Latex Gloves | |
| Other | |
| | |

5. FAMILY HISTORY: Has any blood relative had the following: ____ Patient denies any family history

| Condition | Relationship | Condition | Relationship | Condition | Relationship |
|---|---|---|---|---|---|
| Cancer | | Heart Disease | | Hypertension | |
| Diabetes | | Anesthesia | | Other | |

6. SOCIAL HISTORY: ____ Patient denies any social history

Tobacco: ____ Never ____ Minimal ____ Yes ( ____ packs/day for ____ years) ____ Quit ____years ago

Alcohol: ____ Never ____ Minimal ____ Yes ( ____ less than 10 drinks per week ____ more than 10 drinks per week)

Recreational Drugs: ____ Never ____ Minimal ____ Yes Type: ________________________________________

7. PREGNANCY:

Are you currently pregnant? ____ YES ____ NO If yes, how many weeks? ____

Printed name of person completing this form: ___________________________________Relationship to patient: _____________

Signature: _____________________________________________________________ Date: _____________________

# Basic Demographics Patient Information

## Demographical Information

Name: (Last) ______________________ (First) ____________________ (MI) ____ Date of Birth: ___________
Social Security Number: ______________________ Gender: (Circle One) Male Female
Address: _______________________________ City: _____________ State: ____ Zip: ________ County: ______
Phone Numbers: Cell: ______________ Can you receive text messages? YES NO Home: ________________
Work: _____________ Message Phone: ____________ Email Address: __________________________________
Preferred way of communication: (Circle One) Cell Phone Home Phone Work Phone Message Phone Email
Do we have permission to contact you and leave messages on your preferred communication method? Yes No

Marital Status: (Circle One)

-Single -Married -Separated -Divorced -Widowed

Race: (Circle One)

-Asian -African Am./Black -Caucasian/White

-Am. Indian/Alaska Native -Native Hawaiian/Other Pac. Islander -Other

Ethnicity: (Circle One)

-Hispanic or Latino -Not Hispanic or Latino

Veteran Status: (Circle One)

-Veteran -Non-Veteran -Unknown

## Pharmacy Information

We offer a prescription discount with both Kroger locations in Marion, Wal-Mart in Marion, and Kroger in Mt. Gilead

Pharmacy: ___________________________ Location: __________________________________

## Legally Responsible Parent or Guardian Information (If applicable)

Name: (Last) ______________________ (First) ____________________ (MI) ____ Date of Birth: ___________

Social Security Number: _______________ Gender: (Circle One) Male Female

Relationship to patient: _______________ Legal custodian: YES NO Residential parent: YES NO

## Insurance Information

Insurance Company Name: ____________________________ Policy Holder's Name: ______________________

Patient's Relationship to Policy Holder: ___________________ Policy Holder's Date of Birth: ________________

Policy Holder's Social Security Number: __________________ Policy Holder's Phone Number: _______________

## Emergency Contacts

Name: _____________________________ Relationship: ______________ Contact Number: _______________

Name: _____________________________ Relationship: ______________ Contact Number: _______________

## We offer the following services and care at the listed locations:

**Marion: Primary Medical, Dental, Counseling, Optical**
**Mount Gilead: Primary Medical, Dental, Counseling**
**Galion: Primary Medical, Dental, Counseling**

# Basic Demographics Privacy Practices, and Rights and Responsibility

Name: (Last)____________________ (First)_______________ (MI) _____ Date of Birth: ____________

Printed Name of Parent or Legal Guardian (If applicable): ________________________________________

## Notice of Privacy Practices Acknowledgement

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 and indirectly.

*Obtain payment from third-party payers.

*Conduct normal healthcare operations such as quality assessments and physicians' certifications.

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.

I received a copy of your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my PHI. I have read the document and understand the information.

## Notice of Rights and Responsibilities Acknowledgement

I understand that this organization has the right to change its NOTICE OF RIGHTS AND RESPONSIBILITIES from time to time and that I may contact this organization at any time to obtain a current copy of the NOTICE OF RIGHTS AND RESPONSIBILITIES. I received a copy of your NOTICE OF RIGHTS AND RESPONSIBILITIES containing a more complete description of the guidelines of rights and responsibilities I have while a patient. I have read the document and understand the information.

**Signature: ________________________________________________ Date: __________________**

**Witness Signature: ________________________________________ Date: __________________**

**If you do not agree to these terms, we will be unable to serve as your provider.**

## Basic Demographics Self-Declaration of Income

**Name: (Last)____________________ (First)____________________ (MI) _____ Date of Birth: ____________**

**Printed Name of Parent or Legal Guardian (If applicable): __________________________________________**

# Are you eligible for a DISCOUNT?

# Lower your healthcare costs with us!

### How many people are in your household: _______

(Number of people you are financially responsible for in your home or number of people you claim on your taxes.)

### How much is your TOTAL household monthly income?

(Please circle an amount closest to your monthly income)

| | | | |
|---|---|---|---|
| 0 | 500 | 1000 | 1500 |
| 2000 | 2500 | 3000 | 3500 |
| 4000 | 4500 | 5000 | Other: _________ |

**If we find you eligible for any discount or assistance program we offer,**

**verification of all income must be on file before any benefit could begin.**

## Basic Demographics Community Survey

**How did you hear about us?** Please circle all those that apply:

Facebook Billboard Website Radio Newspaper Pamphlet Friend/Relative

Other: (Please Specify) _____________________________________________

**What do you like about us?** Please circle all those that apply:

Staff Cleanliness Location Speed Atmosphere Cost

Other: _______________________________________________________

**How did you arrive at your appointment today?** Please circle one of the following:

Drove own vehicle Friend/Relative Bus/cab Walk

**Do you have any suggestions to improve your visit with us?**

_____________________________________________________________________________________________

_____________________________________________________________________________________________

Thank you for taking the time to complete our survey. Your input is greatly appreciated.

**Dental Release** **HIPAA Authorization**

Name: (Last)___________________ (First)__________________ (MI) ____ Date of Birth: ____________

Printed Name of Parent or Legal Guardian (If applicable): __________________________________________

## Health Insurance Portability and Accountability Act (HIPAA) Authorization

I authorize **Center Street Community Health Center (CSCHC) and Morrow Family Health Center (MFHC), Galion Family Health Center (GFHC)** to use and disclose my following **Protected Health Information (PHI)** listed below for the purposes listed elsewhere on the page.

**List individuals you would allow us to share medical information with if necessary.**

| Name of entity or person | Relationship to patient | Telephone Number |
|---|---|---|
| | | |
| | | |

Upon supplying proof of identity by showing acceptable form of photo identification, the above listed person(s) may have access to my: medications, prescriptions, documentation in sealed envelope, appointment time, and any life-threatening, emergency information.

**This Protected Health Information (PHI) is being given or disclosed for the following purpose(s): Continuity of Care**

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer at Center Street Community Health Center Corporate office. I understand that revocation is not effective to the extent that my provider has relied on the use or disclosure of the PHI or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. The use or disclosure requested under this authorization may result in direct or indirect remuneration to the provider from a third party.

If the disclosure concerns a patient in an alcohol or drug abuse program, the following notice shall accompany the disclosure: This information has been disclosed to you from our records protected by federal confidentiality rules (442CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**I SPECIFICALLY AUTHORIZE THE DISCLOSURE TO & RELEASE FROM THE ABOVE NOTED AGENCIES REGARDING THE INFORMATION BELOW:**

___ Mental Health Information- current diagnosis & medication list

___ Substance abuse (including alcohol/drug abuse)

___ STD related information (STD testing)

___ HIV related information (AIDS related testing)

**Signature: ______________________________________________________ Date: _____________**

**Witness Signature: _______________________________________________ Date: _____________**

**If you do not agree to these terms, we will be unable to serve as your provider.**

## Dental Release Treatment Consent

Name: (Last)____________________ (First)_______________ (MI) _____ Date of Birth: _____________

Printed Name of Parent or Legal Guardian (If applicable): ___________________________________________

## Treatment Consent

I understand that treatment provided to me by any medical, dental, nursing students, LISW, or PsyD staff will be properly supervised by a licensed practitioner. I am giving permission for any exams, tests, or other services that the provider believes are needed. Center Street Community Health Center (CSCHC), Morrow Family Health Center (MFHC), Galion Family Health Center (GFHC) make sure that all staff who need to be licensed by the State of Ohio have the proper credentials.

I understand and agree that I will participate in the planning of my care, treatment, and/or services. I understand that I may stop care, treatment, and/or services at any time. I also understand that there are no guarantees that treatment will be successful.

**CSCHC, MFHC, and GFHC have the right to treat me without consent only in three situations:**

1) Emergencies 2) When non-verbal communications show implied consent 3) When legally bound to treat.

**Signature: _____________________________________________________ Date: ____________________**

## HIE Notice Language

I understand that Center Street Community Health Center, Morrow Family Health Center, and Galion Family Health Center participate in one or more Health Information Exchanges. My healthcare providers can use this electronic network to securely provide access to my health records for a better picture of my health needs. They, and other healthcare providers, may allow access to my health information through the Health Information Exchange for treatment, payment, or other healthcare operations. This is a voluntary agreement. I understand that I may opt-out at any time by notifying the Health Information Management Services/Medical Records Department OR the office administrator.

**Signature: _____________________________________________________ Date: ____________________**

**Witness Signature: ______________________________________________ Date: ____________________**

**If you do not agree to these terms, we will be unable to serve as your provider.**