Catherine's HEALTH CENTER

Dental Health History Form

Please complete the following form to the best of your ability. Your answers are for our records only and will be kept **confidential**. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information will only be used to provide you the best possible care.

Full Legal Name of Patient

Date of Birth (MM/DD/YYYY)

If you are completing this form for another person, please provide your name:

Your full legal name

Relationship to patient

Dental Information

Do you have bleeding or sore gums when you brush or floss?	☐ Yes	☐ No
Are your teeth sensitive to cold, hot, sweets, or pressure/biting?	☐ Yes	☐ No
Do you have food impaction or floss catching between your teeth?	☐ Yes	☐ No
Do you have dry mouth?	☐ Yes	☐ No
Do you have an unpleasant taste or bad breath?	☐ Yes	☐ No
Do you have a burning tongue or lips?	☐ Yes	☐ No
Do you have frequent blisters, sores, or ulcers on lips or in mouth?	☐ Yes	☐ No
Do you have swelling or lumps in your mouth?	☐ Yes	☐ No
Do you have clicking, popping, or discomfort in the jaw?	☐ Yes	☐ No
Do you have difficulty opening or closing your jaw?	☐ Yes	☐ No
Do you have loose teeth?	☐ Yes	☐ No
Do you have any chipped or broken teeth?	☐ Yes	☐ No
Do you have any shifting of your teeth?	☐ Yes	☐ No
Do you have a change in your bite?	☐ Yes	☐ No
Do you have earaches, headaches, or neck pain?	☐ Yes	☐ No
Have you ever had orthodontic (braces) treatment?	☐ Yes	☐ No
Are you currently experiencing dental pain or discomfort?	☐ Yes	☐ No

If "yes," please describe:

Do you clench or grind your teeth? ☐ Yes ☐ No

Do you bite your cheeks or lips? ☐ Yes ☐ No

Do you wear any removable dental appliances (complete or partial dentures)? ☐ Yes ☐ No
If "yes," date they were made: _____

Have you ever had a serious injury to your head or mouth? ☐ Yes ☐ No

If "yes," please describe:

Do you participate in active recreational activities? ☐ Yes ☐ No

Have you ever had any problems associated with previous dental treatment? ☐ Yes ☐ No

Have you ever had any problems with dental anesthetic? ☐ Yes ☐ No

Have you had any periodontal (gum) treatments? ☐ Yes ☐ No

Have you ever been told you need antibiotic pre-medication for dental treatment? ☐ Yes ☐ No

Is your home water supply fluoridated? ☐ Yes ☐ No

Do you drink bottle or filtered water? ☐ Yes ☐ No

If "yes," how often? ☐ Daily ☐ Weekly ☐ Occasionally

Date of your last dental exam:	Date of your last dental x-rays:
Previous Dentist:	

What was done at this time?

Please rate your comfort level with receiving dental treatment.

☐ Completely comfortable ☐ Moderately Comfortable ☐ Slightly Comfortable ☐ Uncomfortable

How do you feel about your smile?

What type of dental treatment do you feel you need?

Oral Hygiene

Do you brush? ☐ Yes ☐ No

How many times per day?

☐ 1 ☐ 2 ☐ 3 ☐ 4

My brush is... ☐ Soft ☐ Medium ☐ Hard

Electric? ☐ Yes ☐ No

Do you use dental floss? ☐ Yes ☐ No

How many times per day?

☐ 1 ☐ 2 ☐ 3 ☐ 4

Do you use a fluoride rinse? ☐ Yes ☐ No

How many times per day?

☐ 1 ☐ 2 ☐ 3 ☐ 4

☐ Other

If "other," please explain:

I would like additional information about:

- ☐ Bleaching
- ☐ Cosmetic Dentistry
- ☐ Dentures
- ☐ Implants
- ☐ Endodontics
- ☐ Special learning needs identified
- ☐ Other

Catherine's HEALTH CENTER

Patient Registration Form

Please complete the following form to the best of your ability to register as a patient of Catherine's Health Center. Your responses will remain confidential along with your medical information. Ask our staff if you have any questions.

Legal Last Name, First Name, Middle Name Today's date

First Name Used (if different than above): _____

Legal sex: ☐ Male ☐ Female **Previous Name (if needed):** _____

Date of birth Social security number

Street Address:	**City**	**State:**	**Zip:**
Home Phone Number:	**Cell Phone Number:**	**Is it okay to text this number? Y N** **Is it okay to send automated calls to this number? Y N**	
Email address:			

Emergency Contact Name:	
Relationship:	**Phone Number:**

Name of next of kin (if same as emergency contact, please write "same") _____

Employment: ☐ None ☐ Employer Name: _____

Primary Language: ☐ English ☐ Spanish ☐ Other _____

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ White ☐ Black or African American ☐ Pacific Islander ☐ Native Hawaiian ☐ More than one race ☐ Decline to answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to answer

Relationship Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner

Sexual Orientation: ☐ Lesbian ☐ Gay ☐ Straight/heterosexual ☐ Bisexual ☐ Unsure
☐ Choose not to disclose ☐ Other (please specify): _____

Gender Identity: ☐ Male (cisgender) ☐ Female (cisgender) ☐ Transgender Male
☐ Transgender Female ☐ Choose not to disclose ☐ Other (please specify): _____

Sex assigned at birth: ☐ Male ☐ Female

Pronouns: ☐ he/him ☐ she/her ☐ they/them ☐ Other (please specify): _____

Are you:

Homebound? ☐ Yes ☐ No ☐ Decline to answer

An agricultural worker? ☐ Yes ☐ No ☐ Decline to answer

A patient of a school-based health center? ☐ Yes ☐ No ☐ Decline to answer

A veteran? ☐ Yes ☐ No ☐ Decline to answer

A public housing resident? ☐ Yes ☐ No ☐ Decline to answer

Do you own a house or are financially responsible for your current living arrangement ☐ Yes ☐ No
(i.e. pay rent, mortgage?)

If yes, do you have a standing legal agreement to reside at this location? ☐ Yes ☐ No

If no, please check any of the following boxes if they apply to your current living arrangement:

	Staying with friends or family		Residing in a mobile vehicle
	Living in transitional housing (shelter, halfway house, group home, etc)		Part of a housing program (Housing choice Voucher Program "Section 8," Habitat for Humanity, etc.)
	Living in a non-permanent accommodation (hotel, motel, hostel, etc.)		Living in poor conditions that would be considered uninhabitable (overcrowded, causing illness, etc.)
	Experiencing homelessness		Decline to answer

Insurance Information (if you have insurance)

Insurance:	**Subscriber's Name:**	**Group #:**	**Policy #:**
Insurance Phone Number:		**Insurance Fax Number:**	

How did you hear about us? Please check all that apply:

Advertising

- ☐ Search Engine/Online Search
- ☐ Billboard
- ☐ Bus
- ☐ Online

Television

- ☐ Advertisement (Specify) _____
- ☐ News/Morning Show Segment (Specify) _____

Outreach

- ☐ Event (Specify) _____
- ☐ Information Table (Specify location) _____
- ☐ Community Organization Referral (Specify): _____

Other

- ☐ Primary Care Physician
- ☐ Specialist Physician
- ☐ Word of Mouth
- ☐ Hospital
- ☐ Insurance Company
- ☐ Townline Elementary
- ☐ Crossroads Bible Church
- ☐ Other

Catherine's HEALTH CENTER

Patient Privacy

Your medical information is personal and private. We are committed to protecting it. Our HIPAA notices, privacy policies, and patient bill of rights & responsibilities can be found on our website and posted in our lobby. They are also made available to you in print upon request from our staff.

How we share your personal health information:

1. **To share with you:** Upon your request, you have a right to access your health records as defined in 45 CFR 164.501 as a designated record set.
2. **For care or treatment purposes:** We may consult with other medical professionals on our team and share your health information. We may also work with outside providers and share your health information for coordinating care.
3. **For payment:** Your insurance or payer may require us to share some of your health information in order to cover your services. You may restrict the disclosure of your health information to your insurance or payer for payment and then be responsible for these charges.
4. **For business operations:** We may share limited and primarily de-identified health information for quality assessment purposes, licensing, and other business needs. Any outside parties with which we partner have written contracts requiring the protection of the privacy of your health information.
5. **Required public health reporting:** The Privacy Rule permits covered entities to disclose protected health information, without authorization, to public health authorities who are legally authorized to receive such reports for the purpose of preventing or controlling disease, injury, or disability.
6. I authorize Catherine's Health Center to access my immunization record history in the Michigan Care Improvement Registry (MCIR) to coordinate records for immunizations and to meet State of Michigan requirements for immunization reporting.
7. I authorize Catherine's Health Center to download my medication history automatically from pharmacy benefit managers (PBMs) as available and necessary.

You may choose to request additional restrictions on the use and disclosure of your protected health information and/or for additional confidential communication. Please ask our staff for documentation to complete.

Full Legal Name of Patient (Please Print) _____ Date _____

Patient/Guardian Signature (Legal Name) _____ Date _____

I authorize Catherine's to release limited medical information to the following individuals:

Name:	Phone Number:	Information to Release:
Name:	Phone Number:	Information to Release:
Name:	Phone Number:	Information to Release:
Name:	Phone Number:	Information to Release:
Name:	Phone Number:	Information to Release:

☐ **Yes** ☐ **No** Catherine's may leave detailed messages on my voicemail about upcoming appointments (if marked "no," we will leave our name, phone number, and request a call back)

☐ **Yes** ☐ **No** Catherine's may leave detailed messages on my voicemail from the clinical team about my health (if marked "no," we will leave our name, phone number, and request a call back)

Patient/Guardian Signature (Legal Name) Date

OFFICE USE ONLY

If it is not possible to obtain the individual's acknowledgment of our privacy practices, describe in the box below the good faith efforts made to obtain the individual's acknowledgment and the reasons why the acknowledgment was not obtained.

Write your response here:

Signature of Center Representative Date

Consent to Treatment

I authorize Catherine's Health Center (Catherine's) and its medical, nursing, and other professional staff members to provide services. I authorize Catherine's professional staff members to administer such diagnostic and therapeutic procedures and treatments, as in the judgment of Catherine's medical personnel, deemed necessary or advisable in my care.

I understand that all medical evaluation and treatment includes a degree of risk. I have the right to inquire about the risks and benefits associated with recommended testing and treatment.

I understand that this Consent to Treatment is valid for each visit I make to Catherine's until revoked by me in writing.

Full Legal Name of Patient (Please Print) _____ Date _____

Patient/Guardian Signature (Legal Name) _____ Date _____

Catherine's HEALTH CENTER

Patient Name: _____

Treatment: _____

Informed Consent for Dental Procedures

You the patient have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should consider the anticipated benefits and commonly known risks of the recommended procedure (written below), alternative treatments (such as extraction, extensive restorations, periodontal (gum) treatment or crowns), or the option of no treat.

By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrences.

As with all dental procedures, there are commonly known risks and potential complications associated with treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than normal result. Even though many of these complications are rare, they can and do occur occasionally.

Some of the more commonly known risks and complications of treatment include, but are not limited to, the following:

- Pain, swelling and discomfort after treatment.
- Infection in need of medication, follow up procedures or other treatment.
- Temporary, or, on rare occasion, permanent numbness, pain, tingling or altered sensation of the lip, face, chin, gums, tongue, along with possible loss of taste.
- Damage to adjacent teeth, restoration of gums.
- Possible deterioration of your condition which may result in tooth loss.
- The need for replacement of restoration, implants or other appliances in the future.
- An altered bite in need of adjustment.
- Possible injury to the jaw joint and related structures requiring follow up care and treatment, or consultation by the dental specialist.
- A root tip, bone fragment or piece of dental instrument may be left in your body, and may have to be removed at a later time if symptoms develop.
- Jaw fracture.
- If upper teeth are treated, there is a chance of sinus infection or opening between the mouth and sinus cavity resulting in infection to anesthetic or medication.
- Need for the follow up care and treatment, including surgery.

If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome. The patient is an important part of the treatment team. In addition to complying with the instructions given to you by the dentist, it is important to report any problem or complication you experience so they can be addressed by your dentist.

This form is intended to provide you with an overview of potential risks and complications. Do not sign this form to agree to treatment until you've read, understood and accepted each paragraph stated above. Be certain all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment.

Patient/Guardian Signature _____ Date _____ Time _____

Dentist Signature _____ Date _____

Witness Signature _____ Date _____

Catherine's HEALTH CENTER

Billing Policy and Sliding Fee Application

Catherine's Billing and Collections Policy

Catherine's Health Center provides access to services regardless of a person's ability to pay. Catherine's accepts a variety of insurance plans, Medicaid, and Medicare. **Patients may qualify for a discount for services—a sliding fee schedule— based on household income and family size.** The sliding fee schedule will be applied to charges for patients who are between 100% and 200% of Federal Poverty Level (FPL). For individuals and households with income at or below 100% of the FPL, Catherine's services will be provided for a minimum fee. Please ask the front desk for more information.

If the patient is responsible for any charges, payment must be made at the time of checkout. Outstanding balances will be directed to a collection's agency. To ensure that everyone who needs care has access to it, Catherine's reserves the right to suspend services to a patient if payment is not made and if the sliding fee application is incomplete or inadequate.

By signing below, I acknowledge that I have reviewed the billing policy information above and/or have requested the additional information I require for full understanding.

Sliding Fee Application

This application is available to every person, regardless of insurance status.

☐ I declare that I am unhoused.

☐ I decline to provide the following information and so acknowledge that I will be ineligible to receive financial assistance. Therefore, if I am responsible for any charges, I will pay the full billed amount.

Full Legal Name of Patient & Signature _____ Date _____

Please list yourself, spouse, and dependents **<u>that you claim on your taxes.</u>**

Name		Date of Birth	Name		Date of Birth
Yourself			Dependent/Age		
Spouse			Dependent/Age		
Dependent/Age			Dependent/Age		
Dependent/Age			Dependent/Age		

Yearly Household Income

Source of Income	Yourself	Spouse	Other	Total Income
Gross wages, salaries, tips, etc.				
Social security & veteran's benefits (circle applicable choices)				
Alimony				
Income from business self-employment, and dependents (circle applicable property)				
Rent (if you own property)				
Total Income				

Verification Checklist

Please attached all copies to this form

☐ **Yes** ☐ **No** *Identification/Address:* Driver's license, employment ID, social security card, or other

☐ **Yes** ☐ **No** *Income required:* Prior year tax return, one month of pay stubs, W-2, social security benefits, support letter, or other

☐ **Yes** ☐ **No** *Insurance:* Insurance card(s)

☐ **Yes** ☐ **No** *Medicaid:* Application made or evidence of rejections

Patient/Guardian Signature (Legal Name) Date

OFFICE USE ONLY

Pay class approved:	**Effective Date:**
Approved by:	**Expiration Date:**

Catherine's HEALTH CENTER

Insurance Waiver

Self-Pay Patient/Non-Covered Service

Catherine's Health Center participates with several insurances. There may be times when you choose to have a non-covered service or see a provider that is not covered by your insurance. For these services, you will have to pay, and it is called an "out-of-pocket cost." You may apply for the Sliding Fee Discount Program to assist with the out-of-pocket costs for those services. Ask our staff if you have questions.

Please initial below next to the appropriate response for yourself/your family today:

_____ I do not have any type of medical/dental insurance. I declare that I am self-pay.

_____ I am aware that my insurance/provider is out of network (not covered by my insurance plan). I choose to continue with services.

_____ I am aware that my insurance/Medicaid does not cover my services. I choose to continue with my services.

Services:

By initialing above and signing below, I confirm that I have been informed and I am aware of my services and the associated costs for today.

_____

Patient Full Name

_____ _____

Signature of Patient Date

_____

Staff Member Name

_____ _____

Signature of Staff Member Date

Catherine's HEALTH CENTER

Catherine's Health Center Dental Appointment Policies

Cancelling an Appointment

It's important that you attend your appointments, because your health matters. But we know life happens. If you need to reschedule an appointment, please call us at (616) 828-0052. If you are unable to get to an appointment on time, or at all, **please notify us 24 hours before your appointment.** This allows us to ensure everyone can receive their needed care.

Missed Appointments

We're committed to offering appointments for all of our patients when they need them. Missed appointments mean missed opportunities to provide care to other patients. To make sure that everyone can access the care they need, **you are only able to miss four appointments per year before we ask that you find care elsewhere.**

If you miss your first new patient appointment without calling to reschedule within **24 hours advanced notice**, you will not be able to get another new patient appointment for 6 months.

Please sign here to indicate you understand our appointment policies:

Patient Signature (Legal Name)	Date
Patient Printed Name	Date