



*Open doors.
Quality care.*

PATIENT FRONT DOOR COVID-19 Screening Checklist

(If patient came by vehicle, instruct to go back to car for screening. If patient without vehicle, screen in foyer area) **NOBODY is to ENTER FACILITY WITHOUT SCREENING**

Patient ID _____ Date _____ Time _____

1. Do you have any of the following symptoms?

New shortness of breath YES NO

Nausea or vomiting YES NO

Diarrhea YES NO

New loss of taste or smell YES NO

Cough YES NO

Sore Throat YES NO

History of Fever or chills YES NO

Most recent TEMP _____ Date/time taken _____

2. Have you been practicing social distancing? YES NO

3. Have you or anyone in your home been tested for COVID-19 YES NO

If so, Date: _____ Result: _____ Where: _____

4. Have you been in contact with person(s) with confirmed case of COVID-19? YES NO

If so, date of last contact: _____

5. Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19? YES NO

If patient has:

-Temp of 100.0 or above, slip mask to patient in lobby foyer

-any YES answer to symptom

Patient to wait in car or foyer for provider or triage nurse to advise of next step.

Patient ID # (office use only) _____

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 Name of Patient _____

Date of Birth (MM/DD/YYYY) _____

If you are completing this form for another person, please complete the following:

Your Full Name _____

Relationship to Patient _____

Do you have any of the following diseases or problems? Please check DK if you do not know the answer to the question.

- Yes No DK **Active Tuberculosis**
 Yes No DK **Persistent cough greater than a 3-week duration**
 Yes No DK **Cough that produces blood**
 Yes No DK **Been exposed to anyone with tuberculosis.**

If you answered yes to any of the items above, please STOP and return this form to the front desk.

DENTAL INFORMATION

Please check DK if you do not know the answers to the question.

- | | |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Do your gums bleed when you brush or floss?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Are your teeth sensitive to cold, hot, sweets, or pressure?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Does food or floss catch between your teeth?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Is your mouth dry?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Have you had any gum treatments?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Have you ever had braces or other orthodontic treatment?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Have you had any problems associated with previous dental treatment?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Does your water at home have fluoride?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Are you currently experiencing dental pain or discomfort? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Do you have earaches or neck pains?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Do you have any clicking, popping, or discomfort in the jaw?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Do you grind or brux your teeth?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Do you have sores or ulcers in your mouth?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Do you wear dentures or partials?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Do you participate in active recreational activities?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Have you ever had a serious injury to your head or mouth?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Do you drink bottled or filtered water?
<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally If yes, how often? |
|---|---|

Date of last dental exam (mm/yyyy):	Date of last dental x-rays (mm/yyyy):	What was done at your last dental exam?
What is the reason for your dental visit today?	How do you feel about your smile?	

MEDICAL INFORMATION

Yes No DK **Are you under the care of a medical provider?**

If yes, and not at Catherine's Health Center, please provide the following information:

Provider name:	Phone Number:		
Street Address:	City:	State	Zip

If no, would you like information about medical services provided by Catherine's? Yes No

Date of last physical exam: _____

Yes No DK Are you in good health?

Yes No DK Has there been any change in your general health within the past year?

If yes, what condition is being treated? _____

Yes No DK Have you had a serious illness, operation, or been hospitalized in the past 5 years?

If yes, what was the illness or problem? _____

Yes No DK Are you taking or have you recently taken any prescription or over the counter medicines?

If yes, please list all, including vitamins, natural or herbal preparations, and/or dietary supplements:

Yes No DK Do you wear contact lenses?

Yes No DK Do you use controlled substances

(drugs)?

Yes No DK Have you had an orthopedic total joint (hip, knee, shoulder, elbow, finger) replacement?

If yes, what date of replacement: _____ If yes, have you had any complications? _____

If yes, please provide the surgeon's name and telephone number: _____

Yes No DK Are you pregnant? If yes, number of weeks along: _____

Yes No DK Are you taking birth control pills or hormonal replacement? Yes No DK Are you nursing?

Yes No DK Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexfenfluramine), or phen-fen (fenfluramine-phentermine combination)?

Yes No DK Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease?

Yes No DK 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? If yes, date treatment began: _____

Are you allergic to or have you had a reaction to any of the following (if yes, please specify the type of reaction):

Yes No DK Local anesthetics _____

Yes No DK Penicillin or other antibiotics _____

Yes No DK Barbiturates, sedatives, or sleeping pills _____

Yes No DK Sulfa drugs _____

Yes No DK Codeine or other narcotics _____

Yes No DK Latex (rubber) _____

Other _____

Yes No DK Aspirin _____

Yes No DK Iodine _____

Yes No DK Animals _____

Yes No DK Food _____

Yes No DK Metal _____

Yes No DK Hay fever/seasonal _____

Yes No DK Nut allergy

Please indicate if you have or have not had any of the following diseases or problems:

	Yes	No	DK
Heart murmur			
Mitral valve prolapse			
Artificial heart valves			
Rheumatic fever			
Cardiovascular disease			
Angina			
Arteriosclerosis			
Congestive heart failure			
Coronary artery disease			
Damaged heart valves			
Heart attack			
Low blood pressure			
High blood pressure			
Congenital heart defects			
Pacemaker			

	Yes	No	DK
Cancer/chemotherapy/radiation treatment			
Chest pain upon exertion			
Chronic pain			
Diabetes Type I or Type II			
Eating disorder			
Malnutrition			
Gastrointestinal disease			
G.E. Reflux/persistent heartburn			
Ulcers			
Thyroid problems			
Stroke			
Glaucoma			
Hepatitis, jaundice, or liver disease			
Severe weight loss			
Sexually transmitted disease			

	Yes	No	DK
Abnormal bleeding			
Anemia			
Hemophilia			
HIV/AIDS			
Rheumatoid arthritis			
Arthritis			
Autoimmune disease			
Lupus			
Asthma			
Bronchitis			
Emphysema			
Sinus trouble			
Blood transfusion			
Neurological disorders			
Epilepsy			

Rheumatic heart disease			
Mental health disorders			
If yes, please specify:			
Severe headaches/migraines			

Excessive urination			
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?			
Osteoporosis			
Night sweats			

Fainting spells or seizures			
Sleep disorder			
Kidney problems			
Persistent swollen glands in neck			

Please list any disease, condition, or problem not listed above that you think is important for your care team to know about:

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and their staff will rely on this information only for treating me. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist, or any other member of their staff, responsible for any action they take or do no take because of errors or omission that I may have made in the completion of this form.

Signature of Patient / Legal Guardian

Date

FOR COMPLETION BY DENTIST/DENTAL STAFF
Notes/additional comments:



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.

Today's Date:	Last Name:	Middle Initial:	First Name:
Date of Birth:	Age:	Social Security Number:	

First Name Used (if different than above): _____

Pronouns: he/him she/her they/them _____

Street Address:	City	State:	Zip:
Best Phone Number (Circle One) Cell Home Work	Email address:		

Relationship Status: Single Married Divorced Widowed Partner

Legal sex: Male Female

Gender Identity: Male (cisgender) Female (cisgender) Genderqueer Transgender Male
 Transgender Female Choose not to disclose _____

Sexual Orientation: Lesbian Gay Straight/heterosexual Bisexual Pansexual Asexual Unsure
 Choose not to disclose _____

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

Primary Language: English Spanish Other _____

Are you:

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:

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

Employment: None Employer Name: _____

Emergency Contact Name:	
Relationship:	Phone Number:

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

- | | |
|--|--|
| <input type="checkbox"/> Search Engine (Google, Bing, Yahoo, etc.) | <input type="checkbox"/> Hospital |
| <input type="checkbox"/> Recommended by a friend/family/colleague | <input type="checkbox"/> Insurance Company |
| <input type="checkbox"/> Social Media | <input type="checkbox"/> Specialist Provider |
| <input type="checkbox"/> News Story | |
| <input type="checkbox"/> Other: _____ | |



Catherine's Patient Privacy

HEALTH DENTAL CENTER

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 of our staff.

How we may share your personal health information:

1. **To share with you:** Upon your request, you may always access your own health records in their fullness.
2. **For care or treatment purposes:** We may consult with other medical professionals on our team and share your health information. This disclosure is only for the purpose of your care plan. Your authorization is always required to share any health information with another medical professional not on staff with us.
3. **For payment:** Your insurance or payer may require us to share some of your health information in order to cover your services. If you are uninsured, you may restrict the disclosure of your health information for payment.
4. **For business operations:** We may share health information for quality assessment purposes, licensing, and other business needs. Any outside parties, such as a licensing body, have written contracts to protect the privacy of your health information.

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.

Full Name of Patient

Date of Birth (MM/DD/YYYY)

Catherine's may release medical information to the following individuals:

Name:	Relationship:	Name:	Relationship:
Name:	Relationship:	Name:	Relationship:

Yes **No** Catherine's may leave detailed messages on my voicemail in regard to upcoming appointments (if no, we will leave our name, phone number, date & time of appointment).

Yes **No** Catherine's may leave a detailed message on my voicemail from the clinical team in regard to my health (if no, we will leave our name, phone number, date & time of appointment).

By signing below, I acknowledge that I have reviewed the HIPPA notice, privacy policy, and patient bill of rights & responsibilities. By signing below, I affirm that the above information is correct.

Patient/Guardian Signature

Date

OFFICE USE ONLY

If it is not possible to obtain the individual's acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgement and the reasons why the acknowledgement was not obtained.

Name & Signature of Center Representative

Date



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 _____



Billing Policies & Sliding Fee Application

Patient ID (office use only) _____

Catherine's Billing & 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.

Patient / Guardian Signature

Date

Sliding Fee Application

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

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 Name of Patient & Signature

Date of Birth (MM/DD/YYYY)

Please list yourself, spouse, and dependents **that you claim on your taxes.**

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 choices)				
Rent (if you own property)				
Total Income				

Verification Checklist (attach 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

By signing below, I certify that the information shown above is correct. I understand verification is required for approval. I agree to update my proof of household income when it changes and understand that I may be charged full price until proof of income is received.

Patient/Guardian Signature

Date

OFFICE USE ONLY

Pay class approved:	Effective date:
Approved by:	Expiration date:

Catherine's Health Dental Center Appointment Policies



Canceling 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.**

Please sign here to indicate you understand our appointment policies:

Signature

Date