Catherine's
HEALTH CENTER

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.

1211 Lafayette Ave. N.E. Grand Rapids, MI 49505 Office: (616) 336-8800 Fax: (616) 336-9700

Catherine's
HEALTH DENTAL CENTER

Health History Form

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.

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

Catherine's
HEALTH DENTAL CENTER

Health History Form

☐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 **Do you use tobacco (smoking, snuff, chew, bidis)?**
☐Yes ☐No ☐DK **Do you drink alcoholic beverages?**
☐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 (Foxamax) 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 Asprin_____
☐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			

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Health History Form

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:**

Catherine's HEALTH CENTER

Patient Registration Form

Please complete the following form to the est 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 Cell Home Work (Circle One)	**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:

☐	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

Employment: ☐ None ☐ Employer Name: _____

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

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

- ☐ Search Engine (Google, Bing, Yahoo, etc.)
- ☐ Recommended by a friend/family/colleague
- ☐ Social Media
- ☐ News Story
- ☐ Other: _____
- ☐ Hospital
- ☐ Insurance Company
- ☐ Specialist Provider

Catherine's HEALTH DENTAL 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 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 _____

Catherine's
HEALTH DENTAL CENTER

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 **<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 choices)				
Rent (if you own property)				
Total Income				

Catherine's HEALTH CENTER

Billing Policies & Sliding Fee Application

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

Catherine's HEALTH CENTER

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.**

Please sign here to indicate you understand our appointment policies:

Signature _____ Date _____