Catherine's HEALTH CENTER

Patient Front Door COVID-19 Screening Checklist

(If patient came by vehicle, instruct to go back to car for screening. If patient is without a 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
- ☐ Sinus Congestion
- ☐ Cough
- ☐ Sore Throat
- ☐ History of Fever or Chills
- ☐ Most Recent TEMP _____ Date/Time Taken _____

2. Have you or anyone in your home been tested for COVID-19 in the last 14 days/ 2 weeks?

- ☐ Yes, on this date: _____ Result: _____ Where: _____
- ☐ No

3. Have you been in contact with person(s) with a confirmed case of COVID-19 in the last 14 days/ 2 weeks?

- ☐ Yes, on this date: _____
- ☐ No

4. 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 the patient has:

- Temp of 100.0 or above
-Any YES answer to symptom

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

Catherine's HEALTH CENTER

Dental 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 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

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 any 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 ever had any gum treatments?**
☐ Yes ☐ No ☐ DK **Have you ever had braces or other orthodontic treatment?**
☐ Yes ☐ No ☐ DK **Have you ever 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 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

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 tobacco (smoking, snuff, chew, bidis)?**

☐ Yes ☐ No ☐ DK **Do you use controlled substances (drugs)?**

☐ Yes ☐ No ☐ DK **Do you drink alcohol?**

☐ Yes ☐ No ☐ DK **Have you had an orthopedic total join (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 phone 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 taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexfenfluramine), or phen-fren (fenfluramine-phentermine combination)?**

☐ Yes ☐ No ☐ DK **Are you taking or scheduled to be taking either the medications alendronate (Foxamax) or risedronate (Actonel) for osteoporosis or Paget's disease?**

☐ Yes ☐ No ☐ DK **Since 2001, were you treated or are you scheduled to be treated 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)** _____
☐ Yes ☐ No ☐ DK **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 allergies** _____
☐ 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			
Cognitive heart failure			
Coronary artery disease			
Damaged heart valves			
Heart attack			
Low blood pressure			
High blood pressure			
Congenital heart defect			
Pacemaker			
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			

	Yes	No	DK
Hepatitis, jaundice, or liver disease			
Severe weight loss			
Sexually transmitted disease			
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 dentist recommended that you take antibiotics prior to your dental treatment?			

	Yes	No	DK
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/Guardian (Legal Name) Date

For Completion by Dentist/Dental Staff

Notes/Additional comments:

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): _____

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

Date of birth Social security number

Street Address:	**City**	**State:**	**Zip:**
Best Phone Number (Circle One) Cell Home Work		**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 skip.) _____

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 ☐ Pansexual ☐ Asexual ☐ Unsure ☐ Choose not to disclose ☐ _____

Gender Identity: ☐ Male (cisgender) ☐ Female (cisgender) ☐ Genderqueer ☐ Non-binary ☐ Transgender Male ☐ Transgender Female ☐ Two-Spirit ☐ Choose not to disclose ☐ _____

Sex assigned at birth: ☐ Male ☐ Female

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

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
- ☐ 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 of our staff.

How we 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 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 Legal Name of Patient & Signature _____ Date _____

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

Name:	Relationship:	Phone Number:
Name:	Relationship:	Phone Number:
Name:	Relationship:	Phone Number:
Name:	Relationship:	Phone Number:
Name:	Relationship:	Phone Number:

☐ **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 detailed messages 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)

Patient/Guardian Signature (Legal Name) _____ 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 acknowledgment and the reasons why the acknowledgment was not obtained.

Name & Signature of Center Representative _____ Date _____

Catherine's HEALTH CENTER

Patient Legal 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
- 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 (Legal Name) _____ 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 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

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