Catherine's
HEALTH CENTER

Dental Health History Form

Please complete this form to the best of your ability. Your answers are for our records only and will be kept confidential.

Patient Name____ Date of Birth __________

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

Medical Problems/Conditions

- Name of Current Physician____________________ Last date of exam____________
- Would you like information about the medical service provided by Catherine's Health Center? YES / NO
- Have you ever had a serious Illness? YES / NO What did you have? ____________________________
- Are you pregnant or nursing? YES/ NO
- Have you had a joint replacement? YES / NO If so, what was the date? ___________
- Have you had to take Premedication prior to dental treatment due to heart condition or joint replacement? YES / NO
- Do you take any Blood thinner medications? YES / NO
- Do you have a sleeping Disorder? YES / NO IF yes, do you use a CPAP? YES / NO

Check if you have (or you have ever had):

Yes	No	
		Diabetes: Type 1 / 2
		Kidney Disease
		Tuberculosis
		Alcoholism
		Substance Abuse
		HIV/AIDS
		Hepatitis
		Liver Disease
		Respiratory Disease
		Asthma
		Tobacco Use
		Recreational Drug Use
		Bisphosphonate Meds (ex: Fosamax/Actonel)

Yes	No	
		Allergic to Anesthetic
		High Blood Pressure
		Low Blood Pressure
		Stroke: Date__________
		Heart Attack: Date______
		Heart Disease
		Artificial Heart Valve
		Pacemaker
		Cancer
		Radiation Therapy
		G.E. Reflux
		Sinus Trouble
		Kidney Problems

Yes	No	
		Recent weight loss
		Epilepsy: Last episode_______
		Osteoporosis/Osteopenia
		Arthritis: Is it Rheumatoid Y / N
		Bleeding Disorder
		Sickle Cell Anemia
		Mental Health Disorder
		Psychiatric care
		Ulcer
		Stomach Problems
		Autoimmune Disease
		Eating Disorder
		TMJ (Temporomandibular Joint Problems)

Please list all medications you are currently using including: Prescriptions, over the counter, and herbal/holistic medications. Please list dose and amount.

_______________________________ _______________________________
_______________________________ _______________________________
_______________________________ _______________________________

Do you have any food, medication or environmental allergies? YES/NO If yes, please list and note reaction:

_______________________________ _______________________________
_______________________________ _______________________________
_______________________________ _______________________________

Dental History

When was the last time you were seen by a dentist? ____________ What was done? __________________

Last date of known x-rays? _____________ Have you ever had a deep cleaning or scaling and root planning? YES / NO

_______________________________________ ____________________

Patient/Parent/Legal Guardian Signature Date

Catherine's HEALTH CENTER

Patient Registration Form

Patient Information

Last Name:	First Name:	First Name Used:
Date of Birth:	Legal Sex: ☐ Male ☐ Female	Social Security Number:
Consent to Call: ☐ Yes ☐ No	Street Address:	
City:	State:	Zip Code:
Home Phone:	Cell Phone:	May we text you with information regarding your healthcare including appointment reminders? ☐ Yes ☐ No *Standard data/text rates may apply
Email Address:		
Emergency Contact Name:	Relationship:	Phone Number:
Next of Kin Name:	Relationship:	
Parent/Guardian Name (if under 18):	Parent/Guardian Phone Number:	

Demographics

Primary Language	Race	Ethnicity	Sexual Orientation	Gender Identity
☐ English ☐ Spanish ☐ Other: ☐ Decline to Answer	☐American Indian ☐Asian ☐Black or African American ☐Caucasian or White ☐Native Hawaiian ☐Pacific Islander ☐More than one race ☐Decline to answer	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐Decline to answer	☐Lesbian ☐Gay ☐Straight/heterosexual ☐Bisexual ☐Unsure ☐Decline to answer ☐ Other:	☐Male Cisgender ☐Female Cisgender ☐Transgender Male ☐Transgender Female ☐Decline to answer ☐Other:
Agricultural Worker ☐ Yes ☐ No ☐ Decline to answer		**Pronouns** ☐He/him ☐She/her ☐They/them ☐Other: ____________		**Sex assigned at birth** ☐Male ☐Female ☐Prefer not to disclose

Are you a Veteran?	Relationship Status	Living/Housing Situation	Household Annual Income:	
☐ Yes ☐ No ☐ Decline to answer	☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner	☐ My own Home ☐ Staying with friends or family ☐ Non-permanent accommodation ☐ Experiencing homelessness ☐ A mobile vehicle ☐ Part of a housing program ☐ Transitional housing ☐ Decline to answer	☐ None ☐ 0-$5,000 ☐ $5,001- $10,000 ☐ $10,001- $15,000 ☐ $15,001- $20,000 ☐ $20,001-$25,000 ☐ $$25,001- $30,000 ☐ $30,001- $35,000 ☐ $35,001- $40,000 ☐ $40,001- $45,000	☐ $45,001- $50,000 ☐$50,001-$55,000 ☐ $55,001-$60,000 ☐ $60,001-$65,000 ☐$65,001-$70,000 ☐$70,001-$100,000 ☐$100,001 or more ☐ Decline to Answer

Insurance Information

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

Catherine's
HEALTH CENTER

Single Signature Page

I have read and/or received the following forms and policies. Copies are provided to patients upon request.

- Notice of Privacy Practice
- Patient Rights and Responsibilities
- FTCA Notice
- Financial Responsibility

Insurance Authorization and Assignment

I request that payment of authorized medical benefits is made on my behalf directly to Catherine's. I authorize to release any medical information to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to verify plan benefits in accordance with HIPAA health information standards. I authorize payment of service(s), otherwise payable to me under the terms of my private, group employer's or group health insurance plan, directly to Catherine's Health Center. I hereby authorize photocopies of this form to be valid as the original.

Consent to Treat

I authorize Catherine's Health Center 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 treatment, as in the judgement 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 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. My signature below is my acknowledgement that I understand the forms, have read the forms and/or received a copy of the forms and policies listed above, and attest that the registration information I have provided to Catherine's Health Center is true and accurate to the best of my knowledge.

____ ____________________

Patient or Parent/Legal Guardian if patient is a minor Date

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

HIPAA Release

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

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 **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 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 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

Health Center Federal Tort Claims Act (FTCA) Program

To be provided to the individual patient before health care services are provided, except in emergency cases when notice may be provided as soon after the emergency as is practicable or to a parent or legal guardian when the patient lacks legal responsibility for their care under State law.

Notice to Patients

This is to notify you that under Federal law relating to the operation of health centers, the Federal Tort Claims Act (FTCA), (See 28 U.S.C. §§ 1346(b), 2401(b), 2671-80) provides the exclusive remedy for damage from personal injury, including death, resulting from the performance of medical, surgical, dental, or related functions by any health care practitioner, board member, officer, employee, or independent contractor who the Department of Health and Human Services has deemed to be an employee of the Public Health Service. This FTCA medical malpractice coverage applies to deemed health center health care practitioners, board member, officer, employee, or independent contractor who have provided a required or authorized service under Title XIX of the Social Security Act (i.e. Medicaid Program) at a health center site or through offs-site programs or events carried out by the health center.

(See 42 U.S.C. § 233(a), (o)).

The above Federal law and other State and Federal laws including the Federal Volunteer Protection Act of 1997 may cover certain health center health care professionals providing health care services to patients at this health center.

Acknowledged:

Patient Signature:______________________________ Date:______________

Patient Name, Printed Legibly:____