

**PATIENT MEDICAL HISTORY**

PATIENT'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ALTHOUGH DENTAL PERSONNEL TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE OR HAD, OR MEDICATIONS THAT YOU MAY BE TAKING COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

		COMMENTS
DO YOU HAVE CURRENT HEALTH PROBLEMS	YES NO	IF YES, PLEASE LIST:
ARE YOU UNDER A PHYSICIANS CARE NOW	YES NO	
HAVE YOU EVER TAKEN FEN-PHEN/ REDUX	YES NO	
ARE YOU CURRENTLY TAKING MEDICATIONS	YES NO	
DO YOU USE CIGARS/CIGARETTES, PIPE OR CHEWING TOBACCO	YES NO	
HAVE YOU HAD ABNORMAL BLEEDING OR DO YOU BRUISE EASILY	YES NO	
HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION	YES NO	
ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:		
ASPIRIN	YES NO	
LOCAL ANESTHETICS	YES NO	
ANTIBIOTICS	YES NO	BLOOD PRESSURE TAKEN TODAY: _____
CODIENE	YES NO	
LATEX	YES NO	
METALS	YES NO	
OTHER	YES NO	
DO YOU HAVE OR EVER HAD THE FOLLOWING:		
AIDS/HIV INFECTION	YES NO	
ANAPHYLAXIS	YES NO	
ARTHRITIS OR RHEUMATISM	YES NO	
ARTIFICIAL HEART VALVES, JOINT REPLACEMENT OR IMPLANT	YES NO	
ASTHMA, SHORTNESS OF BREATH, LUNG, OR BREATHING PROBLEMS	YES NO	
BACK PROBLEMS	YES NO	
BLOOD DISEASE OR ANEMIA	YES NO	
CANCER OR TUMORS	YES NO	
CHEMICAL DEPENDANCY	YES NO	
CHEMOTHERAPY OR RADIATION THERAPY	YES NO	
CHEST PAIN	YES NO	
CORTISONE TREATMENTS	YES NO	
DIABETES	YES NO	
EATING DISORDER	YES NO	
EPILEPSY OR SEIZURES	YES NO	
FAINTING OR DIZZY SPELLS	YES NO	
GLAUCOMA	YES NO	
HEART DEFECT OR HEART MURMUR	YES NO	
HEART SURGERY/ PACEMAKER	YES NO	
HEART TROUBLE, HEART ATTACK, OR ANGINA	YES NO	
HERPES, COLD SORES, OR FEVER BLISTERS	YES NO	
HEPATITIS, JAUNDICE, OR LIVER DISEASE	YES NO	
HIGH BLOOD PRESSURE	YES NO	
HIVES OR SKIN RASH	YES NO	
HYPOGLYCEMIA	YES NO	
KIDNEY DISEASE	YES NO	
MITRAL VALVE PROLAPSE	YES NO	
NERVOUSNESS	YES NO	
MENTAL HEALTH CARE	YES NO	
PERSISTANT COUGH	YES NO	
SEXUALLY TRANSMITTED DISEASE	YES NO	
RHEUMATIC HEART DISEASE, RHEUMATIC FEVER, OR SCARLETT FEVER	YES NO	
SINUS TROUBLE	YES NO	
STOMACH ULCERS	YES NO	
STROKE OR TIA	YES NO	
SWELLING OF FEET, HANDS OR ANKLES CIRCULATORY PROBLEMS	YES NO	
THYROID PROBLEMS	YES NO	
TONSILLITIS	YES NO	
TUBERCULOSIS OR COUGH THAT PRODUCES BLOOD	YES NO	
WOMEN ONLY		
ARE YOU PREGNANT OR NURSING	YES NO	
ARE YOU TAKING BIRTH CONTROL PILLS	YES NO	

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PROVIDER SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PATIENT DENTAL HISTORY

PATIENT'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

REASON FOR TODAY'S VISIT:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DATE YOU LAST SAW A DENTIST \_\_\_\_\_

NAME OF PREVIOUS DENTIST \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_

DATE OF LAST COMPLETE DENTAL EXAM \_\_\_\_\_

DATE OF LAST FULL MOUTH X-RAYS \_\_\_\_\_

DATE OF LAST CLEANING \_\_\_\_\_

COMMENTS

- DO YOU WEAR COMPLETE OR PARTIAL DENTURES YES NO
- IF YES, HOW OLD ARE THEY \_\_\_\_\_
- HAVE YOU HAD PERIODONTAL THERAPY (DEEP CLEANINGS) YES NO
- ARE YOUR TEETH SENSITIVE TO HOT, COLD SWEETS, OR PRESSURE YES NO
- DO YOU GRIND OR CLENCH YOUR TEETH YES NO
- HAVE YOU WORN BRACES ON YOUR TEETH YES NO
- HAVE YOU EVER NEEDED TO TAKE ANTIBIOTICS PRIOR TO DENTAL APPOINTMENTS YES NO
- HAVE YOU HAD PROBLEMS WITH LOCAL ANESTHETICS YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

DENTIST SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

REGISTRATION

PATIENT INFORMATION

NAME \_\_\_\_\_ DATE \_\_\_\_\_  
FIRST MI LAST

SS# \_\_\_\_\_ SEX: M F BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_

CHECK IF APPROPRIATE: \_\_\_ MINOR \_\_\_ SINGLE \_\_\_ MARRIED

IF PATIENT IS A MINOR, PLEASE LIST ADULTS WHO CAN BE RESPONSIBLE IN MAKING DECISIONS AND IN ACCOMPANYING PATIENT TO ALL APPOINTMENTS

_____	NAME	_____	RELATIONSHIP
_____	NAME	_____	RELATIONSHIP
_____	NAME	_____	RELATIONSHIP

EMERGENCY CONTACT INFORMATION

NAME \_\_\_\_\_  
FIRST MI LAST

RELATIONSHIP TO PATIENT \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

DENTAL INSURANCE INFORMATION

NAME OF INSURED \_\_\_\_\_ SS# \_\_\_\_\_  
FIRST MI LAST

RELATIONSHIP TO PATIENT \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ GROUP # \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_ PHONE # \_\_\_\_\_

INS. CO. ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOW MUCH IS YOUR DEDUCTIBLE? \_\_\_\_\_ MAX ANNUAL BENEFIT? \_\_\_\_\_

CONSENT

I CONSENT TO THE DIAGNOSTIC PROCEDURES DEEMED APPROPRIATE BY THE DENTIST TO MAKE A THOROUGH DIAGNOSIS OF MY DENTAL NEEDS.

I CONSENT TO ALL FORMS OF DENTAL TREATMENT, MEDICATION AND THERAPY BY THE DENTAL ASSISTANT, DENTAL HYGIENIST, AND THE DENTIST THAT MAY BE INDICATED FOR PROPER DENTAL CARE.

I UNDERSTAND THAT PROCEDURES WILL BE DONE WITH LOCAL ANESTHETICS ONLY, WHICH EMBODIES CERTAIN RISKS INCLUDING BUT NOT LIMITED TO: SHORT/LONG TERM NUMBNESS, SHORT/LONG TERM JAW PAIN, BRUISING, PAIN UPON INJECTION, AND NEEDLE BREAKAGE

I GIVE CONSENT TO INNER CITY HEALTH CENTER TO USE AND DISCLOSE MY RECORDS TO CARRY OUT TREATMENT OR TO OBTAIN PAYMENT.

I GIVE CONSENT TO INNER CITY HEALTH CENTER TO ATTAIN APPROPRIATE HEALTH INFORMATION FROM MY PRIMARY CARE PROVIDER(S) IN ORDER TO CARRY OUT PROPER DENTAL CARE

I ATTEST TO THE ACCURACY OF THE INFORMATION I HAVE GIVEN ON THIS PAGE

\_\_\_\_\_  
PATIENT / GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE





**MONTHLY HOUSEHOLD INCOME**

Total Monthly Income \$ \_\_\_\_\_ Source of Income \_\_\_\_\_

**ETHNICITY** Please check one

- Asian
- African American
- Caucasian
- Hispanic
- Native American
- Other \_\_\_\_\_
- I do not want to answer this question

How did you hear about this health clinic? \_\_\_\_\_

What language do you speak? \_\_\_\_\_ What language do you prefer? \_\_\_\_\_

Can we call your home to remind you of appointments?  Yes  No

**Do you have Medical insurance? Medicaid Medicare Commercial Other**

**Name/Address** \_\_\_\_\_

Occupation: \_\_\_\_\_ Church/Religion: \_\_\_\_\_

Education: \_\_\_\_\_ Years High School \_\_\_\_\_ Years College \_\_\_\_\_

**RESPONSIBILITIES AND RELEASES**

I understand that by receiving services from the Provider for my family, or myself I am accepting responsibility for payment of charges. Co-Payment is due before treatment is rendered regardless of insurance coverage. I authorize the release of any medical or other information necessary to process insurance claims. I also authorize payment of insurance benefits to Inner City Health Center directly

**I authorize providers at Inner City Health Center to perform all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk.**

**By signing this document, I verify that the above information is correct and that I agree to notify Inner City Health Center when my financial status changes.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

# INNER CITY HEALTH CENTER DENTAL CLINIC POLICIES

## CANCELLATION OF APPOINTMENT

You must give at least 24 hours notice if you will be unable to attend your scheduled appointment.

## "NO-SHOW" APPOINTMENT

"NO-SHOW" APPOINTMENTS ARE:

- Missed appointments
- Cancelled appointments without 24 hours notice
- 15 minutes late (by our clock) to appointment

FOR EACH "NO-SHOW" APPOINTMENT:

- You will be charged \$15.00.
- The \$15.00 charge must be paid in full before another appointment is given.

AFTER **THREE** NO-SHOW APPOINTMENTS:

- You will be dismissed from our clinic.

## PAYMENT

Payment is due at the time services are rendered.

Unless a prior arrangement has been made with our billing department, **no appointments will be scheduled until your balance due is paid,**

## DENTAL PROVIDER

Inner City Health Center is a private, non-profit, volunteer based health care facility dedicated to providing quality low-cost services. We have several volunteers that provide dental services at our clinic. Inner City Health Center is also a teaching facility for student dentists, dental hygienist, and dental assistants. **A volunteer or student dentist, dental hygienist, or dental assistant may provide the care you receive at our clinic.** A clinical faculty member for the respective schools supervises the student dentists, dental hygienists, or dental assistant in order to assure the best possible treatment.

If you do not consent to having treatment provided by students or volunteers, our clinic may not be suited for you.

## UNATTENDED CHILDREN

Inner City Health Center cannot be responsible for unattended children. Children under the age of 12 will not be allowed to wait in the reception area unattended. Children will not be able to wait in the clinical areas either. If you do not provide child-care during your scheduled appointment, you will not be seen and your appointment will be rescheduled.

## COSMETIC DENTISTRY

Inner City Health Center can not guarantee a cosmetic outcome to any restoration or prosthesis we provide. We strive to restore your dentition to be functional at a discounted fee. The esthetics of our restorations / prosthesis will be limited by time, ability, and materials available. If you have any expectations regarding the esthetics of the dentistry we will provide, our clinic may not be suited for you.

I have read and understand the policies regarding:

- Cancellation of appointments
- "No-show" appointments
- Dental providers
- Unattended children
- Cosmetic dentistry

I understand my responsibilities and I give my consent to be treated by a student or volunteer dentist, dental hygienist, or dental assistant.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

S:\Dental\IHC Dental Clinic Policies1105.DOC



**Acknowledge of Receipt of  
Notice of Privacy Practices**

I have received this office's Notice of Privacy Practice, which explains how my medical information may be used and disclosed. I understand that I am entitled to receive a copy of this document.

\_\_\_\_\_  
Signature of Patient or Patient's Representative

\_\_\_\_\_  
Date

This form is to be placed in the Patient's medical file. This form is to be retained for a minimum of six years. Should the Patient choose not to sign this form, please comment below as to why the Patient did not sign and then place this form in the Patient's medical file.

*Comments (if Applicable):*

Form received by:

\_\_\_\_\_  
Name Date