Hamilton Health Center FQHC

Dear parents,

Hamilton Health Center's Downey School-Based Clinic offers medical and dental services. Your child will be escorted from his/her Downey classroom to Hamilton Health Center's Downey clinic for their scheduled appointment during school hours. Your child's insurance will be billed for services. If your child does not have insurance, contact our Certified Application Counselors to see if your child qualifies for insurance. Upon request, a copy of your child's physical exam, immunization record, and dental exam will be sent directly to the school nurse. If you have any questions or concerns, please call (717) 230-3909.

***To enroll your child at our Downey School-Based Clinic, please complete, sign and date the form below.**

I, hereby, give permission for _____ ___/___/___ _____

Name of Child Birth date Downey Classroom

to receive medical and dental services from Hamilton Health Center's Downey School-Based Clinic. I understand that this agreement does not apply to other sites of Hamilton Health Center. I also understand that if I authorize to receive dental services, local anesthesia may be used for the completion of necessary dental treatment. I further understand that by signing this permission form, I am authorizing Hamilton Health Center to bill my child's insurance for services that are rendered.

Please check the boxes that apply:

- o I would like my child to receive ALL of the services Hamilton Health Center offers
- o I would like my child to ONLY receive MEDICAL services including immunizations and behavioral health
- o I would like my child to ONLY receive DENTAL services.
- o I have received and read the Vaccine Information sheets that were provided.
- o YES - I give permission for my child to be seen at Hamilton Health Center's Downey School-Based clinic without me present.
- o NO – I do not give permission for my child to be seen at Hamilton Health Center's Downey School-Based clinic without me present.

To the best of my knowledge, all of the information I have provided is correct. If my child has any future changes in his/her medical history, I will inform the medical doctor or dentist.

_____ _____ _____

Print name of Parent/Legal Guardian Signature of Parent/Legal Guardian Date

_____ _____

Insurance Company Member Policy Number (on card)

_____ _____

Policy Holder Group Number (on card)

Hamilton Health Center FQHC

(EHS pre-populated pt info) Date:

Permission for Dental Treatment and Local Anesthesia (numbing shots)

- ✓ I hereby authorize the dentist to treat me or the person under my care (I am the legal guardian, or close relative) with the following **dental procedures** (if or when needed): prophylaxis (dental cleaning), restorations (fillings), crowns (caps), fixed bridgework (a series of joined caps), full or partial removable dentures, extraction (tooth removal), root canal, or any other treatment the dentist considers necessary.

- ✓ The dentist has fully explained to me the nature and purpose of the procedure(s), and has also explained the expected benefits and potential risks (from known and unknown causes) of the treatment. I have been given alternatives to the treatment, the risks and benefits of the alternatives and the consequences of having treatment withheld. I have been given the opportunity to ask questions, and all of my questions have been answered fully and satisfactorily.

- ✓ I understand that during treatment, unforeseen conditions may arise which may necessitate procedures different from those discussed prior to treatment. I, therefore, consent to the performance of any additional treatment which the dentist considers necessary.

- ✓ I consent to the use of a **local anesthetic, antibiotics and analgesics** (pain medication) and have been explained all potential risks associated with their use. I understand that there is a slight element of risk involved with the use of local anesthesia or the use of any drug. These risks include allergic reaction, aspiration, pain, cardiac arrest, discoloration and injury to blood vessels and nerves which may be caused by injections of any medications or drugs.

- ✓ I have been given no assurances or guarantees as to outcome of the treatment. I realize that in spite of the possible complications, my proposed treatment is necessary and desired by me.

- ✓ I understand that it is vital that I give as **accurate and complete a medical and personal history** as possible, follow any and all instructions as directed and permit prescribed diagnostic procedures.

- ✓ I confirm that I have read and fully understand all of the information provided above.

Signature _____
(Patient or guardian/relative)

Relationship to person above_____

Signature of Dentist_____

DCA091014

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PATIENT INFORMATION

Date: _____ ☐New Patient ☐Update

Patient: _____
Last First MI Suffix Language

☐Male ☐Female ☐Child* ☐Student** ☐Single ☐Married ☐Divorced ☐Widowed

☐Amer Indian or Alaskan Native ☐Asian ☐Black or African Amer ☐Native Hawaiian ☐Other Pacific Islander ☐White

*If Child, provide parent/guardian info below:

Parent/Guardian Name
SSN: ___-__-___
Date of Birth: __/__/____

Parent/Guardian Name
SSN: ___-__-___
Date of Birth: __/__/____

**If Student, please complete: ☐Full-time ☐Part-Time

School/Location

Patient Date of Birth: __/__/____ Patient SSN: ___-__-___

Address: _____
Address Line 1

_____
Address Line 2

_____
City State ZIP Code

Home: _____
Cell: _____

E-Mail: _____

Referral? ☐Yes ☐No Referred by: _____

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

_____ Tel: _____
Name Relationship

EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____

Address: _____
Address Line 1

_____
Address Line 2

_____
City State ZIP Code

Work: _____ X
Direct: _____
Fax: _____

INSURANCE INFORMATION

Subscriber: _____
Last First MI Preferred Title

Subscriber's Date of Birth: _____ Subscriber SSN: _____

Subscriber's Employer: _____

Patient Relationship to Subscriber: ☐Self ☐Spouse ☐Child ☐Other

Primary Insurance Carrier: _____

Group/Policy No.: _____ ID No.: _____

Address: _____
_____
City State ZIP Code

Tel: _____
Toll-free: _____
Fax: _____

Secondary Insurance Carrier: _____

Group/Policy No.: _____ ID No.: _____

Address: _____
_____
City State ZIP Code

Tel: _____
Toll-free: _____
Fax: _____

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PREVIOUS DENTIST INFORMATION

Dentist: _____ Telephone: _____

Clinic/Facility: _____

Address: _____

_____ _____ _____

CITY STATE ZIP CODE

Reason for changing: _____

DENTAL HISTORY

ORAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

Date of Last Dental Visit: _____ Treatment Type: _____

☐Y☐N Are you currently having dental discomfort? If yes, explain: _____

☐Y☐N Any unhappy/unpleasant dental experiences? If yes, explain: _____

☐Y☐N Any injuries to mouth/teeth/head? If yes, explain: _____

☐Y☐N Any missing teeth other than wisdom teeth or orthodontic extractions?

☐Y☐N Have missing teeth been replaced?

☐Y☐N Orthodontic appliances now or in the past?

☐Y☐N Gums bleed when brushing or flossing?

☐Y☐N Concerned about gum disease? History of gum disease? ☐Y☐N

☐Y☐N Any concerns about the appearance of your teeth?

☐Y☐N Does it hurt to bite or chew?

☐Y☐N Do you clench or grind your teeth? If so, do you wear a night guard or splint? ☐Y☐N

☐Y☐N Do you want to become a regular continuing care patient in our practice?

☐Y☐N Do you want your mouth properly restored and pain free?

☐Y☐N Does any type of dental treatment make you nervous? If yes, please explain below:

☐Y☐N Has the patient had dental x-rays done previously?

The most important concerns regarding my dental treatment are:

What factors are most important for your satisfaction with our office?

Any additional concerns/comments?

CHILD/MINOR PATIENTS: PLEASE ANSWER THE FOLLOWING QUESTIONS:

☐Y☐N Any mouth habits? (thumb sucking, nail biting, mouth breathing, nursing/bottle habits, pacifier, etc.)

☐Y☐N Any unusual speech habits? If yes, explain: _____

☐Y☐N Any lost teeth? If yes, list: _____

☐Y☐N Does the patient receive assistance with brushing and flossing? If yes, how often?

☐Y☐N How many times does the patient drink soda/sugary drinks/fruit juices in a day?

☐Y☐N Were any teeth removed by extraction? Was this space recommended to be maintained? ☐Y☐N

☐Y☐N Does your child receive fluoride?

PRIMARY PHYSICIAN INFORMATION

Physician: _____ Telephone: _____

Clinic/Facility: _____

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MEDICAL HISTORY

GENERAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

☐Y☐N Under a physician's care now?
☐Y☐N Any hospitalization in the past 5 years? _____
☐Y☐N Any serious illnesses/surgeries? _____
☐Y☐N Use tobacco in any form? If Yes, Type: _____
☐Y☐N Is pre-medication required before dental visits due to heart condition or artificial joint?
☐Y☐N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*
☐Y☐N Any medical or dental problems now? If yes, explain:

FEMALE PATIENTS: ☐Y☐N Currently nursing? ☐Y☐N Currently pregnant? Due Date: _____

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? ☐Y☐N
If yes, please describe:

Is there anything important about your medical condition we have not asked? ☐Y☐N If yes, please describe:

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ACID REFLUX
☐ADHD
☐AIDS/HIV
☐ANEMIA
☐ANOREXIA
☐ANXIETY
☐ARTIFICIAL HEART VALVE
☐ARTIFICIAL JOINTS
☐ARTHRITIS
☐ASTHMA
☐AUTISM/ASPERGER'S
☐BLEEDING DISORDER
☐BIRTH DEFECT
☐BULIMIA
☐CANCER/MALIGNANCY
☐CEREBRAL PALSY
☐CHEMICAL DEPENDENCY
☐CHEST PAIN
☐CHICKEN POX
☐CONVULSIONS
☐DEPRESSION
☐DIABETES
☐DIZZINESS/FAINTING
☐EPILEPSY/SEIZURES
☐FREQUENT EAR INFECTIONS
☐FREQUENT HEADACHES
☐HEARING PROBLEMS
☐HEART ATTACK
☐HEART DISEASE
☐HEART MURMUR
☐HEPATITIS
☐HIGH BLOOD PRESSURE
☐HOSPITALIZATION (DATE:)
☐KIDNEY DISEASE
☐LIVER PROBLEMS
☐MENTAL RETARDATION
☐MITRAL VALVE PROLAPSE
☐MONONUCLEOSIS
☐OTHER – PLEASE LIST:
☐PACEMAKER
☐PSYCHIATRIC TREATMENT
☐RADIATION/CHEMO
☐RESPIRATORY DISEASE
☐RHEUMATIC FEVER
☐SINUS PROBLEMS
☐STROKE
☐SURGERY (DATE & WHY:)
☐THYROID CONDITION
☐TUBERCULOSIS (POS OR NEG)
☐ULCERS
☐VENEREAL DISEASE

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ASPIRIN
☐ANESTHETIC – LOCAL
☐BARBITURATES
☐CODEINE
☐DAIRY
☐LATEX
☐LACTOSE INTOLERANCE
☐METAL SENSITIVITY
☐NITROUS OXIDE SEDATION
☐SLEEPING PILLS
☐SULFA DRUGS
☐PENICILLIN/OTHER ANTIBIOTICS
☐NONE
☐OTHER – PLEASE LIST: _____

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ANTIBIOTICS/SULFA DRUGS
☐BLOOD THINNERS
☐INSULIN
☐OTHER DIABETIC MEDICATIONS
☐ANTIHISTAMINES/ALLERGY
☐CANCER/CHEMO MEDICATIONS
☐NITROGLYCERIN
☐RECREATIONAL DRUGS
☐DAILY ASPIRIN
☐CORTISONE/STEROIDS
☐ORAL CONTRACEPTIVES
☐THYROID MEDICATIONS
☐BLOOD PRESSURE MEDICATIONS
☐HEART MEDICATION/DIGITALIS
☐OSTEOPOROSIS MEDICATIONS
☐TRANQUILIZERS
☐OTHER (PLEASE LIST BELOW)

DRUG NAME	DOSAGE	REASON PRESCRIBED

Hamilton Health Center FQHC

Financial Guidelines

We are committed to providing you with the best care possible to achieve total oral health. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines.

Insurance

We accept all major dental insurance payments; however, we may not be a network provider for your plan. If we are not a network provider, review your plan details, as in many cases insurance reimbursement is very similar.

- **We are in network for United Concordia, Delta Dental, Blue Cross Dental, Gateway, UPMC, United Health Care, Amerihealth Mercy, Aetna Better Health, Metlife.**
- **No estimate is a guarantee of payment.** Please understand, you are responsible for all charges not paid by your insurance. Also, many insurance companies are excluding certain dental procedures or downgrading procedures to a lesser reimbursement level; in which case, you would be responsible for the difference.
- **Workers Compensation claims** will be filed for you. Please understand the carrier will assign a dollar amount that will be paid towards the claim, which may or may not cover the entire fee. Any amount not covered by the carrier, will be your responsibility.
- **Minors must be accompanied by a parent or legal guardian at our 17th Street site**. If the parents are separated or divorced, the person accompanying the minor will be responsible for copayment at the time of service.

Payments

- **Patient portion or patient co-pay is due at the time services are rendered** - unless prior financial arrangements have been made.
- **Payment Information:**
  - The following major credit cards are accepted (Visa and MasterCard)
- **Balances-** we realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Short Cancelled/ Missed Appointments

- **Please give 48 hours notice** if you are unable to keep your reserved time. Unless an emergency occurs, we expect to run on time for your appointments, and we appreciate the same courtesy from you.
- **Short canceled or missed appointments** will be considered a no show. Should you miss 3 consecutive appointments within the current year, you will not be allowed to schedule an appointment for 6 months. At that point, you will only be allowed to be seen for urgent care only. Should you miss 6 consecutive appointments within the current year, you may discharged from our practice.

By signing below I acknowledge I have read and understand the guidelines above.

Signature: Date:

Hamilton Health Center FQHC

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices.* I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: **Date:**

RELATIONSHIP TO PATIENT: ☐ADULT PATIENT ☐PARENT ☐GUARDIAN ☐OTHER

Please list any dependent children under the age of 18 also covered by this acknowledgement:

☐ I give permission for the following communications to be used by Hamilton Health Center **(please check all that apply)** :

☐ Cell phone: ☐ Text Message reminders permitted
☐ Home phone ☐ Work ☐ E-Mail:

☐ I am granting permission for Hamilton Health Center to disclose their identity to anyone who may answer my home, work or cell phone.

☐ I am granting permission for Hamilton Health Center to leave a message with any person who may answer my phone or on my voicemail of the following numbers **(please check all that apply)**:

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ None- please just ask for a call back
☐ Other (Please explain)

I would like to give permission for the following person(s) to have access to personal information including but not limited to appointments, treatment, and billing of me and any dependent children listed above:

PATIENT CONSENT- PAYMENT AUTHORIZATION – SIGNATURE ON FILE

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medication changes, I shall inform the dentist and staff at the next appointment without fail.

I hereby authorize payment directly to Hamilton Health Center of the dental benefits otherwise payable to me.

I hereby authorize Hamilton Health Center to release any information concerning my health or dental care, advice, treatment or supplies provided. This information is to be used in administering dental claims and/or discussing treatment options with other dental professionals.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered.

By signing below, I acknowledge that I have read and understand the statements mentioned above.

Signature: Date:

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

☐The patient refused to sign ☐Communication barriers ☐Emergency situation ☐Other – please list: