

## **Dental Clinic**

### ***Establishing Care***

#### **What do I need to bring to my first appointment?**

- Insurance cards.
- Picture ID, state-issued and current.
- Payment for today's visit.
- A list of all medications you currently take, both prescribed and over the counter, including supplements and vitamins.
- Completed new patient paperwork – downloaded from our website or received in the mail.
- Completed slide application and acceptable proof of income if you are applying for our Sliding Discount Program.
- X-rays taken within the last year. If a full mouth series or panoramic film was taken within the last five years, please bring that as well. If films are to be sent from another office please verify prior to your appointment we have received them to avoid delaying your appointment.

State law requires that a dental office have copies of the requested information available within two weeks, originals are retained by the original provider.

#### **Do I need to confirm my appointment?**

As a courtesy, you will receive a text or call reminder prior to your appointment. Please be aware that, if we are unable to reach you, we do request that you **CALL US** to confirm your appointment at least **24 hours** ahead of your appointed time. Without this confirmation, your appointment may be cancelled.

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**We ask that you please arrive 15 minutes early to your first appointment to allow time to complete registration. Late registration may require the appointment to be rescheduled.**



## Patient Registration

### How did you hear about us?

- Doctor Referral     
  Friend / Family Referral     
  Yellow Pages     
  Google Search     
  Billboard  
 Newspaper (please list publication) \_\_\_\_\_  
 Magazine (please list publication) \_\_\_\_\_  
 Radio (please list station) \_\_\_\_\_  
 Social Media (please list app) \_\_\_\_\_  
 Other: \_\_\_\_\_

### 1 Patient Demographics

Full Name: \_\_\_\_\_ Nickname: \_\_\_\_\_  
 Maiden Name / Former Name: \_\_\_\_\_  
 SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Birth Sex:  Female  Male  
 Billing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Day Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Marital Status:  Single  Married  Widowed  Divorced  Separated  Domestic Partner  
 Employment Status:  Employed  Homemaker  Retired  Student  Unemployed  Disabled  
 Primary Language:  English  Spanish  Sign Language  Other: \_\_\_\_\_  
 Do you need an interpreter?  Yes  No  
 Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Emergency Contact Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_  
**\*\*If you would like this person to be able to discuss your medical care and/or billing issues, please request an Authorization Form.\*\***  
 Primary Pharmacy: \_\_\_\_\_ Secondary Pharmacy: \_\_\_\_\_

### 2 Insurance Information – Please provide your insurance card(s)

Name of Primary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_  
 Policy Holder Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Name of Secondary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_  
 Policy Holder Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### 3 Minor Patients Only

Mother's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Father's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**4 Patient Statistics**

As a Federally Qualified Health Center, we are able to offer services to all our patients, including the underserved, as a result of funding from Federal Grants. In order to receive grant dollars, we are required to gather, on a yearly basis, statistics about the patients we serve. This information is confidential and will be used for statistics purposes only. We appreciate you taking the time to complete all questions in this section.

**What is your living status?**  Homeless  Not Homeless **Are you a Migrant Farm Worker?**  Yes  No

**What is your race?**  White  Black / African American  American Indian / Alaska Native  
*(mark all that apply)*  Asian Indian  Asian Other  Chinese  Filipino  Guamanian or Chamorro  
 Japanese  Korean  Other Pacific Islander  Samoan  Vietnamese

**What is your Ethnicity?**  Chicano  Cuban  Hispanic, Latino, or Spanish  Mexican American  
 Mexican  Puerto Rican  Spanish  Not Hispanic/Latino/Spanish Combined

**Are you a Veteran?**  Yes  No

**Gender Identity?**  Declined  Female  Male  Genderqueer  Transgender F to M  
 Transgender M to F  Other

**Sexual Orientation?**  Declined  Straight / Heterosexual  Lesbian / Gay  Bisexual  Something Else  
 Don't Know

**What is your Gross Annual Household Income?** \_\_\_\_\_ **How many people are in your household?** \_\_\_\_\_

**If over age 18, what is the highest grade in school you completed?**

Elementary  6th  7th  8th  9th  10th  11th  12th  GED  
 Attended College  Associate's Degree  Bachelor's Degree  Master's Degree

**5 Billing and Collection Policy**

Payments of copays, deductibles and any other amount not covered by insurance is expected at the time of service. Any amount not received at your appointment will be billed on your monthly statement. All statements are due in full upon receipt unless prior financial arrangements have been made. Unpaid balances will be subject to our collection process, which may include assignment to an outside collection agency and possible discharge from the practice.

We will submit a claim to all contracted primary and secondary insurance companies with the exception of motor vehicle claims and out-of-state worker's compensation claims. It is your responsibility to supply us with a current copy of your insurance card(s) at each appointment. We do offer a sliding fee discount based on your income and family size. Please ask our front desk staff for an application.

The Billing Office is open Monday through Friday, 8:00 am to 5:00 pm. We accept all major debit/credit cards, checks, and cash. We also accept Care Credit at our Dental facility. A **\$29** NSF fee will be applied for all returned checks.

I hereby authorize Siskiyou Community Health Center to provide services to the above named patient and to use and release medical or dental information as required for treatment, payment and health care or dental operations. I also assign Siskiyou Community Health Center payments to which I'm entitled for medical, surgical, behavioral health and dental expenses. I have read and understand the above policy regarding my financial responsibility for all services provided, whether covered by insurance or not.

\_\_\_\_\_  
**Patient or Patient Representative Signature**

\_\_\_\_\_  
**Date**

**6 No Show Policy**

An appointment that is not kept, not canceled 24 hours in advance, or is late is called a "No-Show". If you are unable to be at your appointment, it is your responsibility to call and reschedule or cancel the appointment.

**New Patients** – Failure to confirm or cancel your new patient appointment at least 24 hours prior to the appointment time will result in a "no-show" status. New patients that fail to provide appropriate cancellation notice for two (2) appointments will no longer be eligible to establish care with us for twelve (12) consecutive months.

**Established Patients** – If an established patient "No-Shows" four (4) times, they will be notified that they are no longer eligible to schedule future appointments and will be seen in the clinic on a same day basis only.

I have read and understand this "No-Show" policy.

\_\_\_\_\_  
**Patient or Patient Representative Signature**

\_\_\_\_\_  
**Date**

**Authorization to Exchange Verbal Health Information**

**Patient Information:** *(Please print)*

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Exchange Verbal Information To:**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Relationship: \_\_\_\_\_

**Information To Be Disclosed:**

*Initial all that apply.*

_____ Medical Chart Notes	_____ Hospital Reports	_____ Dental Chart Notes
_____ Diagnostic Results	_____ Immunization	_____ Perio Chart
_____ Lab/Pathology	_____ Specialist Consults	_____ Radiographs
_____ Medication/Pharmacy	_____ Billing	_____ Appointment Info.

This authorization may be revoked at any time by notifying a Siskiyou Community Health Center staff member. Such notice will be effective immediately upon receipt by Siskiyou Community Health Center records personnel. This consent will be **valid up to one (1) year.**

Date consent begins: \_\_\_\_\_

Date consent expires: \_\_\_\_\_

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

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

I recognize that the information discussed may contain information that is protected by federal and state laws (i.e. Drug/Alcohol Abuse, Mental Health, HIV/AIDS), and I specifically consent to the disclosure of such information.

***Initial each one that applies:***

\_\_\_\_\_ HIV/AIDS  
 \_\_\_\_\_ Mental Health  
 \_\_\_\_\_ Drug/Alcohol Abuse

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

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

## Patient Privacy

We are required by law to protect the privacy of your medical information and to provide you with a written Notice describing:

### **How Medical Information About You May Be Used and Disclosed and How You Can Access This Information**

- We may use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.
- We may be required or permitted by certain laws, regulations, or circumstances to use and disclose your medical information for certain purposes without your authorization. Under other circumstances we may need your written authorization (that you may later revoke) in order to use or disclose your medical information.
- We participate in the Reliance Health Information Exchange (HIE), which is a system that electronically moves and exchanges Protected Health Information (PHI) between participating healthcare providers, such as hospitals and specialist offices to support activities needed for treatment, payment, and operations purposes. Reliance is a secure system designed according to nationally recognized standards and in accordance with federal and state laws that protect the privacy and security of the information being exchanged. Participating in Reliance supports improved care by getting your healthcare team more complete and accurate information, especially in an emergency. Your PHI is available to authorized healthcare providers unless you opt out. If you wish to opt out, healthcare providers will not be able to search for your records through the HIE, except in the case of a medical emergency. For more information on how to opt out or to cancel a previous opt-out request, contact Reliance at [support@RelianceHIE.org](mailto:support@RelianceHIE.org) or call (855) 290-5443.
- As our patient, you have important rights relating to inspecting and copying the medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.
- We have available a detailed **NOTICE OF PRIVACY PRACTICES**, which fully explains your rights and our obligations under the law. We may revise our NOTICE from time to time. The Effective Date at the bottom right-hand side of this page indicates the date of the most current NOTICE in effect.
- You have the right to receive a copy of our most current NOTICE in effect. If you have not yet received a copy, please ask at the front desk, and we will provide you with one.
- If you have any questions, concerns, or complaints about the NOTICE or your medical information, please contact the HIPAA Privacy Officer at 1-866-667-2870.

**Acknowledgment and Consent**

I understand that Siskiyou Community Health Center (referred to below as “This Practice”) will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by This Practice. It may be in the form of written or electronic records or spoken words and may contain information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other healthcare providers for my care and treatment;
- Determine my eligibility for a health plan or insurance coverage, and submit bills, claims, and other related information to insurance companies or others who may be responsible for paying some or all of my health care; and
- Perform various office, administrative and business functions that support my physician’s efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice’s Notice of Privacy Practices in effect will be posted in waiting/reception areas.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

**By signing below, I agree that I have reviewed and understand the information above and that I have received or been offered a copy of the Notice of Privacy Practices.**

By: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient Signature)

Print Name: \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
(Patient Name)

By: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient Representative Signature)

Print Name: \_\_\_\_\_  
(Patient Representative Name)

Description of Representative’s Authority: \_\_\_\_\_

## Patient Financial Responsibilities

Thank you for choosing Siskiyou Community Health Center for your dental needs. We are committed to providing you with the highest quality dental care possible. We are providing this information regarding our financial policy to better assist you in determining your benefits and understanding your financial responsibility.

### Private Insurance

We must have a copy of your dental insurance card to verify eligibility and process claims. If we do not receive this, we will not be able to bill your insurance, and you will be considered Self-Pay.

***It is your responsibility to communicate with your insurance to determine if services are covered and what amount you will be responsible for.*** For treatment services, we will provide you with a Proposed Treatment Plan indicating the recommended services and their estimated fees. You may use this document when contacting your insurance to assist with determining coverage.

Questions you may want to ask your insurance provider:

1. Does my policy cover this service, and if so, how much does my policy cover?
2. Is there a deductible that I am responsible for?
3. Is there a limit on the number of this type of service I can have in a year? What is the limit?
4. What dates are considered my policy year?
5. Is there a dollar limit on any of the services?

We will contact your insurance prior to treatment to verify coverage and determine if the service requires prior authorization. If so, we will begin that process. If we receive a denial from your insurance for the prior authorization, we will contact you. ***If you choose to proceed with the service, we will not bill your insurance, and you will be considered Self-Pay for the treatment (see Self-Pay expectations on the back page).***

***A payment of 50% of the estimated cost is due before the first treatment appointment.*** If you are unable to make this payment, your appointment will be canceled or rescheduled.

Any balance due after insurance processes the claim will be billed to you and is due ***within 30 days of the statement date.***

***(See other side for additional information)***

## **SELF PAY/SLIDE**

Services provided will be considered 100% patient responsibility, less the sliding fee discount for those who qualify.

For Preventive Services (exams, cleanings, etc) an estimated price range can be provided upon request. If you do not qualify for the Sliding Discount Program, please ask our Registration Staff about our ***Ounce of Prevention Program***. This program offers discounted services for preventive care.

For Treatment (fillings, extractions, crowns, dentures, etc), we will provide you with a Proposed Treatment Plan indicating the recommended services and their estimated fees. You may use this document to assist you in determining what treatment you can afford.

***Payment in full is expected prior to services being performed.*** If you are unable to pay, your appointment will be canceled or rescheduled.

A payment plan may be available for approved situations. Please note that the plan cannot exceed six months and must be paid in full before additional services are performed.

### **\*\* IMPORTANT \*\***

All Proposed Treatment Plans and Estimates are ***estimates only***. The services and/or fees may be subject to change. We will do our best to make sure you have the most accurate financial information you need to make your treatment decisions; however, ***any changes to the estimated services/fees will be considered patient responsibility.***

**Dental Health History**

Patient Name: \_\_\_\_\_

Chart #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**I. Circle Appropriate Answer** (Leave blank if you do not understand the question)

- Yes No** Is your general health good?  
**Yes No** Has there been a change in your health in the last year?  
**Yes No** Are you under the care of a physician?  
*If Yes: Name & Phone:* \_\_\_\_\_  
*What is the condition being treated?* \_\_\_\_\_  
*Date of last medical exam:* \_\_\_\_\_  
**Yes No** Have you been hospitalized or had a serious illness in the last three years?  
*If Yes: Please explain:* \_\_\_\_\_  
**Yes No** Have you had problems with prior dental treatment?  
*Date of last dental exam:* \_\_\_\_\_  
**Yes No** Are you in pain now? *If Yes: Please describe:* \_\_\_\_\_

**II. Do you have or have you had:**

- |                                                  |                                                         |
|--------------------------------------------------|---------------------------------------------------------|
| <b>Yes No</b> Bleeding Problems, Bruising Easily | <b>Yes No</b> Thyroid, Adrenal Disease                  |
| <b>Yes No</b> Sinus Problems                     | <b>Yes No</b> Diabetes                                  |
| <b>Yes No</b> Stroke, Hardening of Arteries      | <b>Yes No</b> Seizures                                  |
| <b>Yes No</b> Heart Disease                      | <b>Yes No</b> Dry Mouth                                 |
| <b>Yes No</b> Heart Attack, Heart Defects        | <b>Yes No</b> HIV or AIDS                               |
| <b>Yes No</b> Blood Transfusions                 | <b>Yes No</b> Tumors or Cancer                          |
| <b>Yes No</b> Heart Murmur                       | <b>Yes No</b> Radiation Treatments                      |
| <b>Yes No</b> Prosthetic Heart Valve             | <b>Yes No</b> Chemotherapy (Pills and/or Injections)    |
| <b>Yes No</b> Pacemaker                          | <b>Yes No</b> STD (Syphilis, Herpes or Gonorrhea)       |
| <b>Yes No</b> Rheumatic Fever                    | <b>Yes No</b> Arthritis, Rheumatism                     |
| <b>Yes No</b> High Blood Pressure                | <b>Yes No</b> Asthma, TB, Emphysema, other lung disease |
| <b>Yes No</b> Artificial Joint                   | <b>Yes No</b> Hepatitis, other Liver Disease            |
| <b>Yes No</b> Stomach Problems, Ulcers           | <b>Yes No</b> Kidney or Bladder Disease                 |
| <b>Yes No</b> Psychiatric Care                   | <b>Yes No</b> Osteoporosis                              |

**III. Are you Taking:**

- Yes No** Recreational Drugs  
**Yes No** Alcohol, Beer, or Wine  
**Yes No** Tobacco (Pipes, Cigars, Cigarettes, Chew)  
**Yes No** Drugs, Medications or over-the-counter medications (including Aspirin), Natural Remedies:  
Please list: \_\_\_\_\_

**IV. Women Only:**

- Yes No** Birth Control Method: \_\_\_\_\_  
**Yes No** Are you or could you be Pregnant or Nursing?

**V. All Patients:**

- Yes No** Do you have or have you had any other diseases or medical problems not listed on this form?  
**If yes, please explain:** \_\_\_\_\_

**Yes No Allergies to: Drugs, Foods, Latex:** \_\_\_\_\_

*To the best of my knowledge, I have answered every question completely and accurately.  
I will inform my dentist of any change in my health and/or medications.*

**Signature of Patient/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_ **Updated** \_\_\_\_\_  
**Signature of Dentist** \_\_\_\_\_ **Date** \_\_\_\_\_ **Updated** \_\_\_\_\_  
**Hygienist Initials** \_\_\_\_\_



## Authorization to Use/Disclose Protected Dental Information

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Healthcare Provider to **Release** Information:

Person/Agency to **Receive** Information:  Patient / Self

Name		
Mailing Address		
City	State	Zip
Phone	Fax	

Name
Siskiyou Community Health Center (SCHC) 1701 NW Hawthorne Ave Grants Pass, OR 97526 P: 541-479-6393 F: 541-472-4701

**Purpose of the Disclosure:**

Transfer of Care     
  Coordination of Care     
  Other: \_\_\_\_\_

**Dates Requested:**

ALL Dates of Service     
 **OR**     
  Date Range: From \_\_\_\_\_ To \_\_\_\_\_

**Information Requested (Must initial each item requested):**

Initial here to include **ALL** types of records indicated below **OR** initial the specific records requested

<input type="checkbox"/> Chart Notes	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Records related to specific injury with following dates: (e.g. Workers Compensation Injury)
<input type="checkbox"/> Patient History	<input type="checkbox"/> Billing Records	
<input type="checkbox"/> Radiology and Imaging Reports	<input type="checkbox"/> Specialist Consults	
<input type="checkbox"/> Dental Exam	<input type="checkbox"/> Diagnosis	
<input type="checkbox"/> Other: _____		

**Effective Date of Authorization**

Until the purpose is fulfilled  
 Other: \_\_\_\_\_

I understand that I may revoke this Authorization in writing at any time by notifying the Medical Records Department. I understand that once my dental information is disclosed to the recipient, SCHC cannot guarantee that the recipient will not re-disclose the dental information to a third party or as required by law. The third party may not be required to comply with this Authorization or privacy laws. I understand that I may refuse to sign this Authorization, and if I do refuse, my ability to obtain treatment will not be affected.

I have read and understood this authorization and had a chance to ask questions about the disclosure of the dental information. I authorize SCHC to use/disclose my dental information in the manner described above.

\_\_\_\_\_  
**Signature of Patient or Person Authorized by Law**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**\*Name and Signature of Witness** (required for release of information about mental illness or developmental disability)

\_\_\_\_\_  
**Date**

**Staff Initials:** \_\_\_\_\_