CENTRAL OZARKS DENTAL CENTER

305 W. Washington, Richland, MO 65556

Patient Name: ____ Date of Birth: ____________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? □**Yes** □**No** **If yes, please list physician's name and name of the medical clinic:**
  ____
- Have you ever been hospitalized or had a major operation? □**Yes** □**No** **If yes,** ____
- Have you ever had a serious head or neck injury? □**Yes** □**No** **If yes,**____
- Have you ever had any abnormal bleeding, associated with previous extractions or surgery? □**Yes** □**No** **If yes,**______________
- Are you taking any medication, pills or drugs? □**Yes** □**No** **If yes, please note on the following page.**
- Have you ever taken Fosamax, Boniva, Actonel, Zometa or any other medications containing bisphosphonates?
  □**Yes** □**No If yes**, ____
- Do you use controlled substances? □**Yes** □**No** if yes, ____
- Do you use tobacco? □**Yes** □**No**

Do you have, or have you had, any of the following?

Aids/HIV Positive □Yes □No	COPD □Yes □No	Hemophilia □ Yes □No	Radiation Treatment □Yes □No
Alzheimer's □Yes □No	Cortisone Medicine □Yes □No	Hepatitis A □Yes □No	Recent Weight Loss □Yes □No
Anaphylaxis □Yes □No	Diabetes □Yes □No	Hepatitis B or C □Yes □No	Renal Dialysis □Yes □No
Anemia □Yes □No	Drug Addiction □Yes □No	Herpes □Yes □No	Rheumatic Fever □Yes □No
Angina □Yes □No	Easily Winded □Yes □No	High Blood Pressure □Yes □No	Rheumatism □Yes □No
Arthritis/Gout □Yes □No	Emphysema □Yes □No	High Cholesterol □Yes □No	Scarlet Fever □Yes □No
Artificial Heart Valve □Yes □No	Epilepsy or Seizures □Yes □No	Hives or Rash □Yes □No	Shingles □Yes □No
Artificial Joint □Yes □No	Excessive Bleeding □Yes □No	Hypoglycemia □Yes □No	Sickle Cell Disease □Yes □No
Asthma □Yes □No	Excessive Thirst □Yes □No	Irregular Heartbeat □Yes □No	Sinus Trouble □Yes □No
Autism/Cognitive Disorder □Yes □No	Fainting /Dizziness □Yes □No	Kidney Problems □Yes □No	Spina Bifida □Yes □No
Blood Disease □Yes □No	Frequent Cough □Yes □No	Leukemia □Yes □No	Stomach/Intestinal Disease □Yes □No
Blood Transfusion □Yes □No	Frequent Diarrhea □Yes □No	Liver Disease □Yes □No	Stroke □Yes □No
Breathing Problems □Yes □No	Frequent Headaches □Yes □No	Low Blood Pressure □Yes □No	Swelling of Limbs □Yes □No
Bruise Easily □Yes □No	Genital Herpes □Yes □No	Lung Disease □Yes □No	Thyroid Disease □Yes □No
Cancer □Yes □No	Glaucoma □Yes □No	Mitral Valve Prolapse □Yes □No	Tonsillitis □Yes □No
Chemotherapy □Yes □No	Heart Attack/Failure □Yes □No	Osteoporosis □Yes □No	Tuberculosis □Yes □No
Chest Pains □Yes □No	Heart Murmur □Yes □No	Pain in Jaw Joints □Yes □No	Tumors or Growths □Yes □No
Cold Sores/Fever Blisters □Yes □No	Heart Pacemaker □Yes □No	Parathyroid Disease □Yes □No	Ulcers □Yes □No
Congenital Heart Disorder □Yes □No	Heart Trouble/Disease □Yes □No	Psychiatric Care □Yes □No	Venereal Disease □Yes □No
Convulsions □Yes □No	Any other serious illness not listed?		Yellow Jaundice □Yes □No

All Patients: Are you allergic to any of the following?

□Aspirin □Penicillin □Codeine □Acrylic □Metal □Latex □Sulfa Drugs □Local Anesthetics

□Nut Allergy □Milk Protein □ Tylenol □Ibuprofen/NSAIDS □Other? ____

Women: Are you…

□Pregnant/Trying to get pregnant □Nursing? □Taking oral contraceptives (birth control pills)?

If pregnant how many weeks? ________ Due Date _________

Signature of Patient, Parent or Guardian:____ Date:_________

Relationship to Patient: ____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's health). It is my responsibility to inform the dental office of any changes in medical status.

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Current Medications

Patient Name: ____ Date of Birth: ________________

Please include prescription, over the counter medications and supplements/vitamins:

Medication Name	Strength	Frequency	Prescribed by:

Pharmacy of Choice: ____

Signature of Patient, Parent or Guardian:____ Date:________________

Relationship to Patient: ____

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Patient Registration Form

Patient Name (Please Print):____

Mailing Address: ____

Street Address:____

Sex: ______Male _____Female **Birth Date**: ______________________

Home Phone: ______________________ **Cell Phone**: ______________________

Email: ________________________________@____________________________

Emergency Contact: ______________________________ Relationship:__________

Home Phone: ______________________ **Work Phone:** ______________________

Preferred Pharmacy:____

Responsible/Insured Party Information:

Name: ____________________________________ **Relationship**: ____________

Address: ____

Home Phone: ( ) ____________________ **Work Phone**: ( ) ____________________

Birth Date:____________________ **Employer**:____________________________

Policy Number:__________________________ **Group Number:**____________________

If you have Medicaid, please list your Medicaid ID Number:______________________

Assignment of Benefits and Authorization to Release Medical Information

I request that payment of authorized benefits Medicare, Medicaid, and/or any Insurance Carrier listed, be made to me or on my behalf to the provider listed on this form, for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release it to the division of Family Services, the Health Care Financing Administration, listed insurer (s), and/or agents of these companies, and/or the listed responsible person(s), any information needed to determine these benefits or the benefits for other related services.

Signature:____________________________________ **Date:**______________________

I have been made aware of the Sliding Fee Discount Program offered by Central Ozarks Medical and Dental Centers. I would like to ***Apply_____*** *or* ***Not Apply____****. If you choose apply, forms to do so will be provided by Reception Staff. If you have not been informed of this program please ask Reception Staff for details.*

If you are enrolled in Medicare, please provide HIC number and sign below

I request payment of authorized Medical benefits be made to Central Ozarks Medical Center, and also authorize any holder of medical information about me to release to the above named Medigap insurer any information needed to determine benefits payable for services from this provider.

HIC Number: __________________

Signature:____________________________________ **Date:**______________________

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Dental Clinic Appointment Policy

Cancellations:

If you cannot come to a dental appointment, please call the clinic at least the day before your appointment. This helps to fill the time with someone who has been waiting for care.

Late Arrival:

If you arrive more than 15 minutes late for a dental appointment or fail to come two times within a year we may not give you a dental appointment. Instead your name will be placed on the call list and you will be called for an appointment when your name comes to the top of the list. In the interim, you will be seen, only as an emergency patient.

Failed Appointments:

If you cancel at the time of your appointment or fail to come two times within a year we may not give you a dental appointment. Instead your name will be placed on the call list and you will be called for an appointment when our name comes to the top of the list. In the interim, you will be seen, only as an emergency appointment.

Children under 16:

We are happy to see children as patients. A parent or guardian must come with them to the clinic and remain in the clinic at all times. A signed and dated permission note by the child's guardian can be used when accompanied by a responsible adult over 18 years of age.

Children **cannot** be left alone in the waiting room or accompany patients to the treatment area, please make arrangements for someone to care for them if you have a dental appointment or need to accompany another minor child in their appointment.

If you understand and agree to this policy, please sign below.

Signature of Patient, Parent or Guardian:____

Relationship to Patient: ____

Date: ____

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Informed Patient Consent

I hereby give permission for the following treatment to be performed on me as a patient of Central Ozarks Medical Center Dental Clinic.

- ○ Examination and/or X-Rays
- ○ Restorative and/or Prosthetics (fillings, crowns, dentures)
- ○ Prophylaxis (cleaning)
- ○ Endodontic (root canal therapy)
- ○ Oral surgery
- ○ Periodontal (gum) Therapy
- ○ Other________________________

I understand that I have the right to refuse any procedure at any time and that no guarantee regarding success or longevity of any dental procedure is implied or expressed. I also understand the possible risks* associated with treatment and have had the opportunity to ask questions of the dental staff to my satisfaction.

____

Signature of Patient, Parent or Guardian Date

____

Relationship to Patient Date

____

Witness Signature Date

Possible risks include, but are not limited to: pain, swelling, infection, total or partial numbness in lips, cheeks or tongue (either permanently or temporarily) and death. Also, due to potentially fatal interaction of certain compounds, I will inform the dental staff if I have used any illegal or illicit drugs or compounds.

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About Our Notice of Privacy Practices

We are committed to protecting your personal health information in compliance with the law. The attached Notice of Privacy Practices states:

- Our obligation under the law with respect to your personal health information.
- How we may use and disclose the health information that we keep about you.
- Your rights relating to your personal health information.
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to uses and disclosures not described in this Notice.
- The person to contact for further information about our privacy practices.

We are required by law to give you a copy of this notice and to obtain your written acknowledgement that you have received a copy of this notice.

Patient Acknowledgement of Receipt

I____________________________, hereby acknowledge that I have received a copy of the

Notice of Privacy Practices.

____

Patient's Signature Date

____

Signature of Parent or Guardian (if applicable) Date

CENTRAL OZARKS DENTAL CENTER

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Date: ___________

I hereby authorize the below listed individuals access to my health information (if this section is not completed, we will only use your medical record for treatment, payment and healthcare purposes. We will not be able to release your medical information to family members or friends unless they are listed by name below):

Individual	**Relationship**
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________

____

Signature of the Patient, Guardian, or Power of Attorney Date

____

If not the patient; please note if you are the Guardian or Power of Attorney

____

Witness Signature: Date

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Patient Demographics

Please fill out the information below for **your household**. Household size is defined as all people living in your home EXCEPT for those you are not financially responsible for. Marital Status is not a factor in determining household. Your information will be kept confidential.

Household Members												
			Race					Ethnicity				
Name	Date of Birth	Primary Language	White	Native Hawaiian/Pacific Islander	Black/African American	Asian	American Indian/Alaska Native	Hispanic/Latino	Homeless	Veteran	COMC Patient
		□English □Other	□	□	□	□	□	□Yes □No	□Yes □No	□Yes □No	□Yes □No
		□English □Other	□	□	□	□	□	□Yes □No	□Yes □No	□Yes □No	□Yes □No
		□English □Other	□	□	□	□	□	□Yes □No	□Yes □No	□Yes □No	□Yes □No
		□English □Other	□	□	□	□	□	□Yes □No	□Yes □No	□Yes □No	□Yes □No
		□English □Other	□	□	□	□	□	□Yes □No	□Yes □No	□Yes □No	□Yes □No
		□English □Other	□	□	□	□	□	□Yes □No	□Yes □No	□Yes □No	□Yes □No
		□English □Other	□	□	□	□	□	□Yes □No	□Yes □No	□Yes □No	□Yes □No
		□English □Other	□	□	□	□	□	□Yes □No	□Yes □No	□Yes □No	□Yes □No

Please mark the income range for the appropriate Household size.

Income Table				
Household Size	Income	Income	Income	Income
1	□ $0 - $11,880	□ $11,881 - $15,800	□ $15,801 - $19,720	□Over $19,721
2	□ $0 - $16,020	□ $16,021 – $21,306	□ $21,307 - $26,593	□ Over $26,594
3	□ $0 - $20,160	□ $20,161 - $26,812	□ $26,813 - $33,465	□ Over $33,466
4	□ $0 - $24,300	□ $24,301 - $33,649	□ $33,650 - $40,338	□ Over $40,339
5	□ $0 - $28,440	□ $28,441 - $37,825	□ $37,826 – $47,210	□ Over $47,211
6	□ $0 - $32,580	□ $32,581- $43,331	□ $43,332 – $54,082	□ Over $54,083
7	□ $0 - $36,730	□ $36,731 - $48,850	□ $48,851 - $60,971	□ Over $60,972
8	□ $0 - $40,890	□ $40,891 - $54,383	□ $54,384 - $67,877	□ Over $67,878

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Consent for Treatment of a Minor

I, ________________________________, consent for treatment of ________________________.
Printed Name of Parent/Guardian Printed Name of Minor

I attest that I have legal responsibility for this patient and the legal right to direct the medical treatment of this patient. I understand that for any treatment to occur, this minor must be accompanied by the adult(s) (over the age of 18) named below.

This consent allows for treatment today and all future appointments. This record may be given to other providers within Central Ozarks Medical Center to treat this minor as needed.

____ _________________________
Signature of Parent/Guardian Date

Please list the names of all adults and their relationship to the minor patient who may accompany this minor to appointments:

_______________________________ _______________________________
Name Relationship to Minor

_______________________________ _______________________________
Name Relationship to Minor

_______________________________ _______________________________
Name Relationship to Minor

_______________________________ _______________________________
Name Relationship to Minor