

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

CENTRAL OZARKS DENTAL CENTER

305 W. Washington, Richland, MO 65556

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: _____

Subscriber Social Security Number: _____

If this is a Armed Forces Insurance please note _____ Active Duty _____ Retired

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: _____

CENTRAL OZARKS DENTAL CENTER

304 W. Washington, Richland, MO 65556

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: _____

CENTRAL OZARKS DENTAL CENTER

305 W. Washington, Richland, MO 65556

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.

CENTRAL OZARKS DENTAL CENTER

304 W. Washington, Richland, MO 65556

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

305 W. Washington, Richland, MO 65556

Date: _____

I hereby authorize the individuals listed below to access 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

CENTRAL OZARKS DENTAL CENTER

304 W. Washington, Richland, MO 65556

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										
Name	Date of Birth	Primary Language	Race			Ethnicity	Homeless	Veteran	COMC Patient	
			White	Native Hawaiian/Pacific Islander	Black/African American	Asian				American Indian/Alaska Native
		<input type="checkbox"/> English <input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> English <input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> English <input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> English <input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> English <input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> English <input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> English <input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> English <input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please mark the income range for the appropriate Household size.

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

CENTRAL OZARKS DENTAL CENTER

305 W. Washington, Richland, MO 65556

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 bring this minor to appointments **and** consent for any and all recommended dental/medical services. *This authorization will remain in effect until changes are made by the parent/guardian signing this form.*

Name

Relationship to Minor

Name

Relationship to Minor

Name

Relationship to Minor

Name

Relationship to Minor

Minor Children (Ages 16 and older)

My child, _____ may be seen for dental attention in the office of Central Ozarks Medical Center – Richland Dental Clinic WITHOUT a parent or legal guardian present. I understand that I will be contacted for treatment plans or any changes in treatment.

Parent/Legal Guardian: _____
