Patient Information

Patient Name: _____ Preferred Name:_____
Last First MI

Gender: ☐ Male ☐ Female ☐ Transgender **Marital Status**: ☐ Married ☐ Single ☐ Child ☐ Other _____

Ethnicity: ☐ Asian ☐ Native Hawaiian ☐ Other Islander ☐ Black/African American **Veteran**: ☐Yes ☐No
☐ American Indian ☐Caucasian ☐ Hispanic/ Latino ☐ Other

Housing Status: ☐ Not Homeless ☐ Homeless Shelter ☐ Temporary Housing ☐ Transitional ☐ Other

Birth Date:_____ Social Security #: _____

Phone (Home): _____ (Work): _____ Ext:_____ (Cell):_____

Address: _____
Street Apartment #

_____
City State Zip Code

Email address: _____

Emergency Contact (Other than Legal Guardian):_____Contact #:_____

Relationship to Patient: _____

Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ (Cell): _____

Address: _____
Street Apartment #

_____

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Social Security Number: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Do you have a Secondary Insurance ☐Yes ☐ No If yes, List the Company Name _____

Referral Information

Whom may we thank for referring you to our practice? ☐ Friend / Family Member ☐ DHS Office

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ WIC ☐ Other_____

Patient Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check all those that apply:

- ☐ ADD / ADHD
- ☐ AIDS /
- ☐ HIV Positive
- ☐ Drug Allergies _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Cystic Fibrosis
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Flouride Suppliment
- ☐ Flouride in Water
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Attack
- ☐ Heart – Artificial Valve
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis ☐ A ☐ B ☐ C
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mentally Handicapped
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Pregnancy** Due date:_____
- ☐ Psychiatric Therapy
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Seasonal Allergies
- ☐ Sinus Problems
- ☐ Speech Problems
- ☐ Stomach Problems
- ☐ MRSA
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Tobacco Usage

OTHER:

- ☐ _____
- ☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____ Name of physician_____
- Are you currently taking any medications? ☐ Yes ☐ No
  If yes, please list: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____

Consent for Services

I herby authorize and direct the provider, and whomever he/she may designate as his/her assistance, to administer such treatment as necessary. I also certify that no guarantee or assurance has been made as to the results that may be obtained. For the purpose of medical and nursing education, I consent to the admittance of observers in the treatment rooms (patient has the right to decline observers during the visit.)

Please understand the necessity of keeping your appointments with the Community Clinic at St. Francis House. It is very important that you keep you appointment and arrive on time. If cancellation is unavoidable, then please give at least 24 hour notice. Please be aware that missing 3 appointments (without 24 hour notice) wi result in you being dismissed as a patient. It is not our intent to be difficult. When a patient misses an appointment it is too late to fill that time slot. That means that another patient needing treatment went without care. Please be considerate of our office and the community of NW Arkansas. Thank you.

Please read and initial each statement:

_____ I understand that if I do not provide proof of income with in 5 days of my first visit and annually thereafter I will not be eligible for sliding scale discounts.
_____ It is my responsibility to report any changes in financial or household size, address or phone number.
_____ Failure to pay on my account could result in my being dismissed as a patient.

I hereby authorize Community Clinic at St. Francis House to furnish all information regarding my medical history, diagnosis and treatment or my children (if applicable) to an insurance company regarding claims for benefits. If, however, said insurer fails to meet this obligation in whole or part, or if I am not insured, I agree to be responsible for the fees and costs involved in the treatment of the above named patient. I authorize payment of medical benefits to Community Clinic at St. Francis House. I hereby authorize Community Clinic at St. Francis House to act on my behalf in accessing hospital medical records when and if I need them. I have received a copy of the Community Clinic's Notice Of Privacy Practices (HIPAA form)

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have