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**Patient Registration Form**

**2020**

**For Dental use only
40% 60% 80%%**

**PATIENT INFORMATION:**

Name:  Middle Initial:

*(LAST/SURNAME) ( FIRST NAME)*

Date of Birth: // Age: 

 (MONTH) ( DAY) (YEAR)

**New Patients** **Returning Patients\***
**\*Returning patients -** If your health history has not changed, please skip the health history portion of this form (Pages 7-9)

 Gender: Male Female  Transgender: Male to Female  Transgender: Female to Male Gender Nonconforming

 Other gender identity not listed above:  Prefer not to answer

Address: County: 

City:  State: Zip: 

Language(s):  Interpreter Needed:  No  Yes

Marital Status: Single  Married Separated  Divorced Widowed Veteran:  Yes  No

**Race/Ethnicity:**

 African

 African-American/Black

 Asian

 Native Hawaiian/Pacific Islander

 Caucasian

 Hispanic/Latino

 American Indian/

Alaska Native

 Arab/Middle Eastern

 Multiracial

 Unknown

 **CONTACT INFORMATION:**

Phone(Primary):  Cell  Home Other:

Phone(Secondary):  Cell  Home Other:

***We may need to contact you. Please check all that we have your permission to leave messages on or with:***

 Voicemail/Texting

 Check here to opt out of receiving text messages

 SPECIFIC Person ONLY, provide the name(s): 

 Another Person: 

**Please list an EMERGENCY contact below:**

, , 

 **(FULL NAME) (PHONE) (RELATIONSHIP)**

Please list any **hospitalizations, surgeries, or ER visits** you have had.

1. Date: 

3.  Date: 

2. Date: 

4.  Date: 

**MEDICAL/DENTAL RECORDS:**

I am currently connected to Lahai Health for:  Dental  Medical  Mental Health Counseling

Are you currently connected to another clinic for medical, dental, or mental health counseling care services?  No  Yes

  Dental  Medical  Mental Health Counseling  Current  Previous

Clinic/Provider Name:

Address: 

 Phone: Fax: 

 Dental  Medical  Mental Health Counseling  Current  Previous

Clinic/Provider Name: 

Address: 

 Phone: Fax: 

  Dental  Medical  Mental Health Counseling  Current  Previous

Clinic/Provider Name: 

Address: 

 Phone: Fax: 

Do you have dental, medical, or mental health counseling records that you would like to have sent to us from past or current clinics?

 No  Yes (*Please ask reception for a Release of Information form and we will request the records)*

**INSURANCE INFORMATION:**

**HEALTH:**

Do you have any forms of health insurance right now?  No  Yes

**If yes**, please identify the type of coverage you have below and *provide a copy of your card to reception*. Common types are (*Medicaid/Apple Health, Medicare, Veteran Benefits, or contracted from the Health Exchange*)

**Insurance Plan:**  **Yearly Deductible: $**

**If no**, have you ever applied for Health insurance? No Yes Date Applied: 

 *(If you applied and were denied coverage, please provide a copy of denial letter to reception.)*

**DENTAL:**

Do you have any dental insurance?  No  Yes

**If yes,** please identify what type of insurance you have and provide a copy of your card to reception (Medicaid/Apple Health, Delta Dental, etc.)

**Dental Insurance:** 

|  |
| --- |
| **Country of Birth:**  **Are you a visitor?**  Yes  No**If Yes**: What is the date of arrival:  Date of Departure: Reason for visit (Refugee/Asylee, Family, Type of Visa, etc): (If you are applying for asylum, please provide a copy of Asylum application to reception) |

**HOUSEHOLD INFORMATION:**

*Your annual income and your family size are necessary to determine your eligibility. Your answers will be kept on file and in strict confidence.*

***Please choose 1 from the list below to verify your income:***

1. *Income tax return from the previous year*
2. *A copy of your W-2 form*
3. *Two months of paycheck stubs*
4. *Two months of bank statements*
5. *Copies of your social security checks or letter, or other checks you may receive.*

***You must verify your income every year. Please bring a copy to your appointment.***

|  |  |
| --- | --- |
| **Are you employed?**No  Yes | **Patient’s Monthly Employment Income:** |
| **Is your spouse/partner employed?** N/A  No  Yes | **Spouse/Partner’s Monthly Employment Income:** |
| **How many people are supported with the total household income?**  |

Does anyone else in your household have any form of income that supports you (spouse, parent, etc.)? If so, please fill out the following:

|  |
| --- |
| **Other Income** |
| Social Security: | $ |
| Food Stamps: | $ |
| Public Assistance: | $ |
| Retirement Pension: | $ |
| Child Support, Alimony: | $ |
| Other: | $ |
| **TOTAL:**  | $ |

***I do hereby swear or affirm that the information provided above is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for programs at Lahai Health. I further agree to inform Lahai Health if there is a significant change in my income. If acceptance to the Lahai Health programs is obtained under this application, I will comply with all rules and regulations of Lahai Health. I hereby acknowledge that I read the foregoing disclosure and understand it.***

Patient Digital Signature:  Date: 

**PATIENT PRIVACY AGREEMENT**

This notice describes how your medical and personal information may be used and disclosed at Lahai Health. Your protected private information includes personal and demographic information such as your name, address, date of birth, various identification numbers and phone numbers. It also includes all health information relating to your past, present, and future physical or mental health conditions.

We use and disclose your private information in many ways when providing you with care. If our healthcare providers ask you to see a specialist, we may disclose your name and reason for referral to the specialist. If a pharmacy calls us with a refill request, we may confirm your information with them. When we send a specimen to the laboratory, we disclose your name and other demographic information to them. This type of disclosure between our healthcare providers and other care providers is necessary to provide you with the best and most effective care. Your primary health care team may include, but is not limited to: providers, nurses, dietitians, spiritual care & physical therapists.

There are situations where we may release your information without your expressed consent. These situations include but are not limited to: emergencies, required reporting to public health entities, and as required by law enforcement agencies. You may have rights regarding our use of your private information. You have the right to limit disclosure (in writing) of your information. You have the right to know if we disclose your information for non-routine health care purposes. You have the right to see your medical records and request amendments or corrections. This notice will be kept on file. You may file a complaint regarding the disclosure of your information to our Clinic Director.

***I have read and understand the agreement above between Lahai Health and myself regarding the privacy of my information. This agreement will remain in effect until it is revoked in writing by the undersigned.***

Patient Digital Signature:  Date: 

**CONSENT FOR DENTAL, MEDICAL or COUNSELING TREATMENT**

Choose all that apply:  Dental  Medical  Mental Health Counseling

In order to receive quality care, I authorize the release of my medical, dental or mental health counseling information to Lahai Health in order to provide me with care. I authorize Lahai Health to release my medical records to other health care providing agencies for the purpose and benefit of providing health care to me.

I hereby give consent to receive medical, dental or counseling care from Lahai Health and its providers and healthcare staff. If patient is a minor, the patient’s parent/guardian must consent to care and treatment. I understand that there are exceptions when care can be obtained by a minor without parental or guardian consent, based on Washington State law and Federal law.

The information provided on my intake paperwork is accurate to the best of my knowledge and I will inform Lahai Health of any changes in my health, medications, health insurance status, income or contact information.

Privacy Practices are listed above in the “Patient Privacy Agreement”. I understand that I can obtain a personal copy, upon request.

***This authorization will remain in effect for any care received through Lahai Health until it is revoked in writing by the undersigned.***

**Patient Digital Signature:**  **Date:** 

**FINANCIAL AGREEMENT**

**THERE IS A $20.00 DEPOSIT TO MAKE ALL APPOINTMENTS.** The $20.00 will be credited to your account at the completion of the appointment. However, if the appointment is

 Cancelled with less than 48 hours’ notice,

 Initial

 If you arrive more than 10 minutes late for your

 Initial appointment

If you do not show up for your appointment,

 Initial

 **If $20.00 deposit becomes NON-REFUNDABLE;**

 Initial **I understand that a $20.00 deposit is required to remake the appointment.**

**ALL ACCOUNTS ARE DUE AND PAYABLE AT TIME OF SERVICE.** If a procedure requires multiple appointments, payment is required in full at each appointment. We accept cash and major credit cards. All emergency dental services or any dental service performed without previous financial arrangements must be paid for at the time of service.

***If you will not be the financial responsible party and or someone else will be covering the costs of your dental services, please share that information below. If you are the responsible party, please skip the “Financial responsible party section, but sign and date.***

**FINANCIAL RESPONSIBLE PARTY** (if not the patient)

Name:  Relationship: 

Address: 

City: State: 
Zip: 

Home Phone:  Cell Phone: 

***I have read, fully understand, and agree to the above financial policy.***

**Patient Digital Signature:**  **Date:** 

**LAHAI HEALTH MISSED APPOINTMENT POLICY**

It is important that Lahai Health patients keep their appointments. When a patient doesn’t show up for a scheduled appointment, cancels last minute, or arrives late, the clinic’s *very* *limited resources* are wasted when Lahai Health could have served another patient in need of care.

**Rescheduling Appointments**

To reschedule, please call Lahai Health (206-363-4105 MEDICAL: Ext 230, DENTAL: Ext 701, COUNSELING: Ext 231) as soon as you know that you will not be able to keep the appointment, ***at least 48 hours prior to your appointment time***. Please leave a message on the scheduling line if your call is not answered.

**Missed Appointments**

If you miss a scheduled appointment completely, cancel with less than 48 hours’ notice, or arrive more than 10 minutes late, this will be recorded in your electronic chart. **Please note if you arrive late, you may have to be rescheduled, if there is not enough time to complete your visit or procedure.**

If you have **2 missed appointments** (includes late cancels or late shows) within a 1-year time frame, you will not be able to schedule with Lahai Health for a period of 6 months. You will receive a letter from clinic staff notifying you of the date you may return for care.

***I understand the Lahai Health Missed Appointment Policy and agree to follow the terms of this policy.***

**Patient Digital Signature:**  **Date:** 

**SOCIAL HISTORY:**

Where are you currently living? House Apartment  Car  Homeless/Unstable Housing Other: 

Do you feel safe in your current relationship?  No  Yes

Sexual Orientation:  Heterosexual  Homosexual  Bisexual  I prefer not to answer.

Number of Lifetime Sexual Partners:  Number of Sexual Partners in the Last Year: 

Use of Caffeine (Coffee/Tea/Soda):  Never  Rarely  Moderate  Daily  Previously, but I quit.

Use of Alcohol:  Never Rarely Moderate Daily  Previously, but I quit.

Use of Tobacco:  Never  Rarely  Moderate  Daily  Previously, but I quit.

Use of Marijuana: Never Rarely Moderate Daily Previously, but I quit.

Use of Recreational Drugs: Never  Rarely  Moderate  Daily Previously, but I quit.

Exercise:  Never Rarely  Moderate  Daily, Types of Exercise: 

**SPIRITUAL CARE:**

Would you like for someone to pray with/for you or help with faith-based questions?  Yes  No

Do you have other concerns? (For example: Housing, food stamps. Financial assistance, or transportation): Yes  No

**If you answered yes to any of the above**, please ask receptionist to speak with the patient advocate.

(**Dental:** please see receptionist.)

**\*\*\*How did you hear about Lahai Health?**
 Online  Goodwill Screening  Church: 

 Lahai Health Volunteer Family/Friends  Other 

**\*WHEN PAGES 1-6 ARE COMPLETE, PLEASE HAND TO THE RECEPTIONIST WITH A FORM OF ID, ANY INSURANCE CARDS, AND FINANCIAL DOCUMENTATION YOU BROUGHT. \***

**------------------------------------------------------------------------------------------------------**

**RECEPTION USE ONLY:**

[ ]  Clinic Site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Copy of Identification (ID) provided (*indicate type*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Financial Documents provided (*indicate type*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Copy of Insurance Cards provided (*only for patients with any insurance*)

[ ]  Explanation of Financial Standing form completed (*if applicable*)

[ ]  ROI for dental/medical records completed (*if needed*)

[ ]  Signed medical interpreter form (if applicable indicate type): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Specify what percentage patient falls under the Federal Poverty Level

 (*Refer to the FPL chart*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_%

[ ]  **FOR DENTAL USE ONLY:** Circle what percentage discount the patient is approved for: 80% 60% 40%

**PATIENT MEDICAL INFORMATION AND HISTORY**

*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 you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.*

**GENERAL QUESTIONS**

Are you under a physician’s care now?  YES  NO If yes, who is your physician: 

What is your impression of your health?  Excellent  Good  Fair  Poor

Do you have any of the following disease or problems?

|  |  |
| --- | --- |
| Active Tuberculosis?  | Yes  No  |
| Persistent cough greater than 3 weeks in  | Yes  No  |
| Cough that produces blood?  | Yes  No  |
| Been exposed to anyone with Tuberculosis?  | Yes  No  |

Have you ever…

|  |  |
| --- | --- |
| Been hospitalized or had a major operation?  | Yes  No  |
| Had a serious head or neck injury?  | Yes  No  |
| Had an organ transplant?  | Yes  No  |
| Had a joint replacement?  | Yes  No  |
| Had a history of Infective Endocarditis?  | Yes  No  |
| Had an eating disorder?  | Yes  No  |
| Taken Phen-Fen or Redux?  | Yes  No  |
| Taken oral bisphosphonates: ex. Fosamax, Boniva, Actonel  | Yes  No  |
| Taken IV bisphosphonates ex. Bonefos, Aredia, Reclast, Zometal | Yes  No  |

Do you use…

|  |  |
| --- | --- |
| Tobacco?  | Yes  No  |
| Controlled substances?  | Yes  No  |
| Alcohol beverages?  | Yes  No  |

Are you dependent on…

|  |  |
| --- | --- |
| Tobacco?  | Yes  No  |
| Controlled substances?  | Yes  No  |
| Alcohol beverages?  | Yes  No  |

Women, are you…

|  |  |  |
| --- | --- | --- |
|  Pregnant / Trying to get pregnant |  Nursing |  Taking oral contraceptives |

  None of the above

**ALLERGIES**

Are you allergic to any of the following?

  None  Latex  Barbiturates, Sedatives, or sleeping pills

|  |  |  |
| --- | --- | --- |
|  Penicillin |  Sulfa Drugs |  Codeine |
|  Aspirin |  Local Anesthetics |  Other:  |

If Yes, what happens? 

**CURRENT SYMPTOMS:** Indicate if you experience any of the items below by checking the box.

|  |
| --- |
| **Cardiovascular / Heart Problems?** |
| Congenital heart defects  | Y  N   | Angina (chest pain)  | Y  N   | Shortness of breath  | Y  N   |
| Mitral valve prolapse  | Y  N   | Heart attack  | Y  N   | Palpitations  | Y  N   |
| Heart murmur  | Y  N   | Coronary heart disease  | Y  N   | High blood pressure | Y  N   |
| Arrhythmia  | Y  N   | Heat Failure  | Y  N   | Low blood pressure | Y  N   |
| Rheumatic heart disease  | Y  N   | Implanted defibrillator  | Y  N   | Swelling of the ankles  | Y  N   |
| Infective endocarditis  | Y  N   | Pacemaker  | Y  N   | Sleep on many pillows  | Y  N   |
| Artificial heart valves  | Y  N   | Arteriosclerosis  | Y  N   |  |  |

|  |
| --- |
| **Respiratory / Lung Problems?**  |
| Asthma  | Y  N   | Pneumonia | Y  N   | Snoring | Y  N   |  |
| Bronchitis  | Y  N   | Sinusitis | Y  N   | Sleep Apnea  | Y  N   |  |
| Emphysema/COPD  | Y  N   | Persistent cough  | Y  N   | Sarcoidosis | Y  N   |  |
| Tuberculosis | Y  N   |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Diabetes/Endocrine Disorder?**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Diabetes Type 1  | Y  N   | Hypothyroidism | Y  N   | Adrenal gland disorder | Y  N   |
| Diabetes Type 2 | Y  N   | Hyperthyroidism | Y  N   |  |  |

 |

|  |
| --- |
| **Kidney/Urogenital Disorder?** |
| Kidney stones  | Y  N   | Renal failure/Insufficiency  | Y  N   | Dialysis | Y  N   |
| Frequent Urination | Y  N   |  |  |  |  |

|  |  |
| --- | --- |
| **Cancer or Tumors?** |  |
| Malignant  | Y  N   | Benign  | Y  N   |  |  |

|  |
| --- |
| **Neurologic / Nerve Problem?** |
| Stroke  | Y  N   | Feelings of depression  | Y  N   | Seizures/epilepsy  | Y  N   |
| Transient Ischemic Attack  | Y  N   | Feelings of anxiety  | Y  N   | Neuropathies | Y  N   |
| Fainting or dizzy spells  | Y  N   | PTSD  | Y  N   | Multiple Sclerosis | Y  N   |
| Feeling of numbness  | Y  N   | Mental health disorder  | Y  N   | Parkinson’s disease | Y  N   |
| Weakness  | Y  N   | Obsessive/compulsive dis.  | Y  N   | ADD/ADHD  | Y  N   |
| Headache  | Y  N   | Dementia/Alzheimer’s  | Y  N   |  |  |

|  |
| --- |
| **Blood / Hematologic Disorder?** |
| Anemia  | Y  N   | Deep vein thrombosis  | Y  N   | Multiple myeloma  | Y  N   |
| Bleeding disorder  | Y  N   | Sickle cell disease/trait  | Y  N   | Leukemia  | Y  N   |
| Bruise easily  | Y  N   | Thalassemia  | Y  N   | Lymphoma | Y  N   |

|  |
| --- |
| **Gastrointestinal (GI) Disorder?** |
| Acid reflux(GERD)  | Y  N   | Irritable bowel syndrome  | Y  N   | Hepatitis  | Y  N   |
| Heart burn  | Y  N   | Crohn’s disease  | Y  N   | Cirrhosis | Y  N   |
| Ulcers  | Y  N   | Gall stones  | Y  N   | Jaundice | Y  N   |

|  |
| --- |
| **Musculoskeletal / Connective tissue Disorder?** |
| Arthritis  | Y  N   | Gout | Y  N   | Fibromyalgia  | Y  N   |
| Osteoporosis | Y  N   | Lupus  | Y  N   | Sclerodema  | Y  N   |
| Joint replacement  | Y  N   | TMJ disorder  | Y  N   |  |  |

|  |
| --- |
| **Infectious Disease?** |
| HIV | Y  N   | STD  | Y  N   | Cold sores  | Y  N   |
| AIDS  | Y  N   | MRSA | Y  N   | Mononucleosis  | Y  N   |

|  |
| --- |
|  **Head / Eye / Ear / Nose / Throat Problem?** |
| Vision problems  | Y  N   | Glaucoma | Y  N   | Hearing impairment  | Y  N   |
| Wearing contact lenses  | Y  N   | Cataract  | Y  N   |  |  |
| **Dermatologic / Skin Problem?** |
| Psoriasis (dry skin)  | Y  N   |  |  |  |  |

**CURRENT MEDICATIONS:** Please list all medications you are taking (prescribed, over the counter, supplements).

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of Medication** | **Dosage (mg/ml)** | **Frequency** | **Date Started** | **Prescribed By** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

***Please indicate your Preferred Pharmacy we may use for prescriptions:***

Pharmacy: 

Address: 

Phone:  Fax: 

***Please list any current Medical Diagnoses:***

1.  Date Diagnosed: 
2.  Date Diagnosed: 
3.  Date Diagnosed: 

**SIGNATURE**

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.

**Patient Digital Signature:**  **Date:** 

[ ]  **\*PROVIDERS ONLY: As a provider, I have reviewed pages 6, 7, and 8 of this patient’s intake form.**

Provider’s Printed Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Provider’s Signature: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**