Patient Registration Form
2023

Lahai HEALTH

DENTAL USE ONLY:
80% 60% 40%

Name: _____, _____ Middle Initial: ____
(LAST/SURNAME) *(FIRST)*

Date of Birth: _____ /_____ /_____ Age: _____ Veteran: ☐ Yes ☐ No
(MONTH) (DAY) (YEAR)

Gender: ☐ Male ☐ Female ☐ Transgender: Male to Female ☐ Transgender: Female to Male ☐ Gender Nonconforming ☐ Other:_____ ☐ Prefer not to answer

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Were you homeless or had unstable housing in the last 12 months? ☐ No ☐ Yes

Language(s): _____ Interpreter Needed: ☐ No ☐ Yes

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
☐ New Patient ☐ Returning Patient

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: _____

E-mail: _____

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 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_____
2. _____ Date:_____
3. _____ Date: _____
4. _____ Date: _____

MEDICAL/DENTAL RECORDS:

Are you currently connected to a 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 Apple Health? ☐ No ☐ Yes

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*.

☐ Medicaid
☐ Medicare
☐ Dually Eligible (Medicare & Medicaid)
☐ Unknown
☐ Uninsured

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.

Dental Insurance: _____

HOUSEHOLD INFORMATION:

Country of Birth: _____ Years in US: _____ 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)

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 2 from the list below to verify your income:

- *Income tax return from the most current year*
- *A copy of your W-2 form*
- Three most recent *months of paycheck stubs*
- *Three most recent months of bank statements*
- *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 Name (printed): _____

Patient 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 Name (printed): _____

Patient Signature: _____ Date: _____

CONSENT FOR DENTAL, MEDICAL or COUNSELING TREATMENT

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 Name (printed): _____

Patient Signature: _____ Date: _____

FINANCIAL AGREEMENT

THERE IS A 50% DEPOSIT IN ORDER TO SCHEDULE **ALL APPOINTMENTS.** The deposit will go towards your next appointment cost. The below fees will be charged to your account if you….

_____ Initial $40 charge per hour for the time scheduled for canceling less than 2 business days or arriving after 10 minutes.

_____ Initial ***$40.00 per hour deposit becomes NON-REFUNDABLE if no show or canceled less than 2 business days or more than 10 minutes late.***

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 responsibility person and or someone else will be covering the costs of your dental services, please share that information below.

Financial Responsibility if not the patient

Name: _____ Relationship: _____

Address: _____ County: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

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

Patient Name (printed): _____

Patient 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 or COUNSELING: Ext 231, DENTAL: (206)899-4765) as soon as you know that you will not be able to keep the appointment, ***at least*** 2 business days ***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 2 business days, or arrive more than 10 minutes late, the above fee will be assessed, 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 Name (printed): _____

Patient 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): _____

☐ Signed Text Messaging (SMS) consent (if applicable)

☐ 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	Y ☐ N ☐	Thyroid problems	Y ☐ N ☐	Adrenal gland disorder	Y ☐ N ☐
Type 1 ☐ *Type 2* ☐		*Hypothyroidism* ☐			
		Hyperthyroidism ☐			

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: _____

Location: _____

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 Signature: _____ Date: _____

☐ **As a provider, I have reviewed pages 6, 7, and 8 of this patient's intake form.**

_____

Provider's Name (printed)

_____ _____

Provider's Signature Date