Patient Registration Form

DENTAL USE ONLY:
80% 60% 40%

☐ New Patient ☐ Returning Patient

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

Date of Birth: _____ /_____ /_____ Age: _____

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

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 your preferred way of receiving messages*:*

☐ Voicemail ☐ Texting ☐ Check here to opt out of receiving messages

☐ SPECIFIC Person ONLY, provide the name: _____

☐ Another Person: _____

Please list an EMERGENCY contact below:

_____, _____, _____
(FULL NAME) **(PHONE)** **(RELATIONSHIP)**

DENTAL HISTORY

Are you currently connected to a Dental Clinic? ☐ No ☐ Yes

Clinic Name: _____

Provider Name: _____

Address: _____

Phone: _____ Fax: _____

If you have received care from any other Dental Clinic in the last 12 months, please fill out the following accordingly:

Clinic Name: _____

Provider Name: _____

Address: _____

Phone: _____ Fax: _____ ☐ Current ☐ Previous

Do you have dental records from past or current clinics that you would like to have sent to us?

☐ No ☐ Yes -*Please ask reception for a Release of Information form*

On a scale from 1-10 how anxious are you of receiving dental treatment, with 1 being not anxious at all and 10 being extremely anxious?

_____

Have you had any negative experiences receiving dental care in the past? If yes, please explain.

_____

Do you have any additional information you'd like to provide us to best serve your dental needs?

_____

DENTAL INSURANCE INFORMATION

Do you have dental insurance? (Including Medicare/Apple Health/Medicaid) ☐ No ☐ Yes

Dental Insurance: _____

INCOME AND STATUS

Country of Birth: _____ Years in US: _____ Are You a Veteran? ☐ Yes ☐ No

Have you ever enlisted to the U.S Army? ☐ Yes ☐ No Are you a visitor? ☐ Yes ☐ No

If yes, what is the date of arrival? _____ Date of Departure: _____

Reason for your visit (Refugee, Asylee, Family, Type of Visa: work, etc.) _____

(If you are applying for asylum, please provide a copy of Asylum application to reception)

Your annual income and the size of your family will determine your eligibility to Lahai Health's Dental Program. Your answers will be kept on file and in strict confidence.

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

- Three most recent months of paycheck stubs
- Letter of Support
- Letter of Income Verification
- Explanation of Financial Standing

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

Are you employed? ☐ No ☐ Yes	**Patient's Monthly Income:**
Does anyone else in your household support you financially? (Spouse, partner, parent, etc.) ☐ No ☐ Yes	**Additional Monthly Income**:
How many people are supported with the total household income? _____	

Are there any forms of additional income in your household? If so, please fill out the following:

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

I swear and affirm that the information I provided is true and correct to the best of my knowledge. I understand that any misleading, withheld, or false information may disqualify me from further consideration or admission to the dental program at Lahai Health. I further agree to inform Lahai Health of any significant changes in my income. If acceptance to the Lahai Health dental program is obtained under this application, I agree to comply with all the rules and regulations. I hereby acknowledge that I read the foregoing disclosure and understood 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 have to confirm personal 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 for you to receive the best and most effective care from us.

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 patient privacy agreement and that I can obtain a personal copy of the information upon request. This agreement will remain in effect until it is revoked in writing by the undersigned.

Patient Name (printed): _____

Patient Signature: _____ Date: _____

CONSENT FOR DENTAL TREATMENT

In order to receive quality care, I authorize the release of my medical or dental 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 healthcare to me.

I hereby give consent to receive dental care from Lahai Health and its providers and healthcare staff.

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 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

ALL ACCOUNTS ARE DUE AT TIME OF SERVICE. If a procedure requires multiple appointments, payment is required in full at each appointment. We accept cash (we appreciate exact amount as we may not have change for bigger bills) 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 someone else is ***covering the costs of your dental services, please share that information below.***

Person financially responsible (NOT THE PATIENT)

Name: _____ Relationship: _____

Address: _____ County: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

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

Patient Name (printed): _____

Patient Signature: _____ Date: _____

APPOINTMENT POLICY

It is important that our patients keep their appointments. When a patient doesn't show up for a scheduled appointment, cancels last minute, or arrives late, we lose the opportunity to serve other patients in need of low cost, quality, and accessible dental care. For this reason, **if you need to cancel or reschedule an appointment, please call us AT LEAST 2 business days prior to your appointment time at (206)899-4765.**

If your call is not answered, please leave a detailed message, and if your appointment falls on a Monday, please call on the Thursday prior to your appointment.

TARDINESS: If you arrive more than 10 minutes late to an appointment, it is likely we will need to reschedule your appointment for lack of time.

MISSED APPOINTMENTS: If you **miss more than 2 appointments without prior notification** within a year, you will not be able to schedule appointments for 6 months. You will receive a letter notifying you when you can schedule again.

I have read and understood the 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 ☐ N/A

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

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: _____

***<u>WHEN PAGES 1-6 ARE COMPLETE</u>, PLEASE PROVIDE THE RECEPTIONIST A FORM OF ID, ANY INSURANCE CARDS (FOR INSURANCE EXCEPTION ONLY), AND FINANCIAL DOCUMENTATION YOU BROUGHT. ***

<u>RECEPTION USE ONLY:</u>

☐ 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%

MEDICAL HISTORY

Our mouth is widely connected to our overall health. Underlying conditions that you may have or medications you may be taking could greatly affect the state of your oral health and could have an important interrelationship with the dentistry you will be receiving.

GENERAL QUESTIONS

Are you under a physician's care now? ☐ YES ☐ NO

If yes, who is your physician: _____

How do you consider your health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have any of the following conditions?

Active Tuberculosis	Yes ☐	No ☐
Persistent cough for 3 weeks or more	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 ☐

(Women) are you…

☐ Pregnant / Trying to get pregnant
☐ Taking oral contraceptives
☐ None of the above
☐ Nursing

SYMPTOMS AND CONDITIONS

Indicate if you are experiencing 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 ☐		*Hypothyroidism* ☐			
Type 2 ☐		*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 ☐		

Dermatologic / Skin Problem?
Psoriasis (dry skin) 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 ☐		

ALLERGIES

Are you allergic to any of the following?

☐ None ☐ Latex ☐ Barbiturates, Sedatives, or sleeping pills
☐ Penicillin ☐ Sulfa Drugs ☐ Codeine ☐ Metals: _____
☐ Aspirin ☐ Local Anesthetics ☐ Other: _____

If yes, what happens? _____

CURRENT MEDICATIONS

Please list all medications you are taking (prescribed, over the counter, and 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: _____

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

1. _____ Date: _____
2. _____ Date: _____
3. _____Date: _____

SPIRITUAL CARE

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

Do you have other concerns? (Housing, food stamps, financial assistance, transportation, etc.)

☐Yes ☐ No

If you answered yes to any of the above, please talk to our receptionist or dental team.

*****How did you hear about Lahai Health?**

☐ Online ☐ Goodwill Screening ☐ Church: _____

☐ Lahai Health Volunteer ☐ Family/Friends ☐ Other_____

SIGNATURE

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

Patient Signature: _____ Date: _____

☐ **As a provider, I have reviewed the social and medical history of this patient's intake form.**

**MEDICAL CLEARANCE REQUIRED? YES___ NO ___

_____
Provider's Name (printed)

_____ _____
Provider's Signature Date