MISSOURI Highlands HEALTH CARE

DENTAL & MEDICAL HISTORY

Patient's name: _____ Date of Birth: _____

Reason for today's visit: _____

YES	NO	
☐	☐	Do you have dental pain? If so, please rate the pain from 1 to 10 (worst =10) _____
☐	☐	Are you in good health? If not, how has your health changed recently? _____
		_____
☐	☐	Have you had any serious illnesses/operations/injuries? If yes, please describe: _____
		_____
☐	☐	Do you use tobacco on a daily basis? If so, how much per day? _____
☐	☐	Do you use alcohol or drugs for recreational purposes?
☐	☐	Have you or a family member had any problems with previous dental care?
☐	☐	Are you currently under the care of a physician?

Physician's name _____ Physician's phone number (___) _____

Please list all drug **allergies** and/or adverse reactions: _____

Please list all **current medications**: _____

_____

Have you ever taken these medications? ☐ Zometa ☐ Aredia ☐ Fosamax ☐ Boniva ☐ Actonel

YES	NO	**For women only**
☐	☐	Are you currently on birth control?
☐	☐	Are you pregnant? If yes, how many weeks? _____
☐	☐	Are you nursing?

NOTE: If you are currently using birth control it is important that you understand that antibiotics may interfere with their effectiveness. Please consult your physician.

Do you have, or have you ever had, any of the following? (please check ALL that apply)

☐ ADD/ADHD	☐ Chest pains or angina	☐ HIV/AIDS
☐ Addiction	☐ Cold sores	☐ Kidney disease
☐ Anxiety	☐ COPD or emphysema	☐ Liver disease
☐ Arthritis	☐ Diabetes	☐ Osteoporosis
☐ Artificial heart valve	☐ Epilepsy or seizures	☐ Pacemaker
☐ Artificial joint	☐ Excessive bleeding	☐ Pain management
☐ Asthma	☐ Fainting or dizziness	☐ Psychiatric treatment
☐ Autoimmune disease	☐ GI problems/stomach ulcers	☐ Shortness of breath
☐ Bacterial endocarditis	☐ Head or neck injuries	☐ Sinus/nasal problems
☐ Bleeding disorder	☐ Heart attack	☐ Stroke
☐ Blood disease	☐ Heart disease	☐ Thyroid disease
☐ Cancer or tumor	☐ Hepatitis A, B or C	
☐ Chemotherapy or radiation	☐ High blood pressure	

I understand the importance of a truthful medical history to assist the doctor in providing the best care possible. I have had the opportunity to discuss my history with my doctor.

_____ _____ _____

Date Signature of person completing history Doctor's Initials

Thank you for selecting Big Springs Dental Clinic/Poplar Bluff Community Dental Clinic.
If you have any questions, please ask us. We will be happy to help.

Rev. 4/2013

MISSOURI Highlands HEALTH CARE

Missouri Highlands Health Care
PATIENT INFORMATION

Date_____

As a Federally Qualified Health Care Center, we are required by the Bureau of Primary Health Care to collect data on all our patients annually.

PLEASE PRINT

PATIENT NAME: _____ Social Security No. _____

Date of Birth: _____ Gender: ☐ M ☐ F ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Mailing Address _____

City _____ State _____ Zip _____

Physical Address (if different) _____ County of Residence _____

City _____ State _____ Zip _____

Home Phone _____ Cell/Alternate Phone _____

Legal Guardian (if patient is 17 or under): _____

Employed? ☐ Full-time ☐ Part-time ☐ No Employer: _____

Student? ☐ Full-time ☐ Part-time ☐ No **Veteran?** ☐ Yes ☐ No ☐ N/A (17 or under)

Preferred Pharmacy _____ Location _____

GENDER/SEXUAL ORIENTATION

Gender Identity (circle) Male Female Transgender (f-to-m) Transgender (m-to-f)

Gender Queer/Questioning Other_____ Choose not to disclose

Sexual Orientation (circle) Straight/heterosexual Homosexual/Gay Bisexual

Something else_____ Don't know Choose not to disclose

COMMUNICATION

Primary Language: ☐ English ☐ Spanish ☐ Other _____
(Indicate which language)

Missouri Highlands has resources available to assist patients who may need hearing, vision or language assistance. If you need such assistance, please check what kind of assistance you require.

☐ Sign Language ☐ Visual Aides ☐ Interpreter for _____
(Indicate which language)

Preferred method of communication: ☐ Phone ☐ Email ☐ Letter ☐ Patient Portal

ETHNICITY

☐ Hispanic/Latino ☐ Not Hispanic/Latino

MHHC does not discriminate based on age, sex, race, creed, marital status, religion, national origin, disability, sexual preference, public assistance status or criminal record

RACE

Please check ALL that apply: ☐ American Indian or Alaska Native ☐ Black or African American

☐ White ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Decline to Answer

HOUSING STATUS

☐ Not Homeless

☐ Homeless (Without Permanent Housing)

☐ Transitional (Passing from one place to another)

☐ Other (Hotels/Motels or other day-to-day paid for housing)

☐ Street (Living outdoors, in a car, makeshift housing/shelter)

☐ Public Housing (Senior Living or HUD)

☐ Doubling Up (Staying with others temporarily/housing unstable)

☐ Unknown

ANNUAL INCOME

Household Size *Check one* **THEN**	**Annual Income Range** *circle the annual income range on the line beside the household size you have selected.*			
☐ 1 →	$0 – 14,580	$14,581 – 19,391	$19,392 – 24,203	$24,204 – 29,160
☐ 2 →	$0 – 19,720	$19,721 – 26,228	$26,229 – 32,735	$32,736 – 39,440
☐ 3 →	$0 – 24,860	$24,861 – 33,064	$33,065 – 41,268	$41,269 – 49,720
☐ 4 →	$0 – 30,000	$30,001 – 39,900	$39,901 – 49,800	$49,801 – 60,000
☐ 5 →	$0 – 35,140	$35,141 – 46,736	$46,737 – 58,332	$58,333 – 70,280
☐ 6 →	$0 – 40,280	$40,281 – 53,572	$53,573 – 66,865	$66,866 – 80,560
☐ 7 →	$0 – 45,420	$45,421 – 60,409	$60,410 – 75,397	$75,398 – 90,840
☐ 8 →	$0 – 50,560	$50,561 – 67,245	$67,246 – 83,930	$83,931 – 101,120

ACCOUNT TO BE PAID BY: *If someone other than the patient*

Name: _____ D.O. B. _____

SS# _____ Relationship to Patient _____

Home Address **(if different than the patient's)** _____

City _____ State _____ Zip _____

Home Phone: _____ Cell/Alternate Phone _____

PLEASE PRESENT YOUR INSURANCE CARD

Thank you for selecting Missouri Highlands Health Care. If you have any questions, please ask us. We will be happy to help.

MISSOURI Highlands HEALTH CARE

MISSOURI HIGHLANDS – DENTAL

Dental Appointment Guidelines

_____ **Confirming Appointments**

(Initial) All appointments MUST be confirmed no later than 48 hours in advance. MHHC Dental Offices will attempt to contact patients, but it is ultimately the patient's responsibility to confirm their appointment.
UNCONFIRMED appointments will be cancelled

_____ **Missed Appointments**

(Initial) First Missed/Unconfirmed Appointment: Will be rescheduled.
Second Missed/Unconfirmed Appointment: 24- hour appointments will be offered for 6 months.
Third Missed/Unconfirmed Appointment: No appointments will be made for 12 months.

_____ **Late Arrival for Appointments**

(Initial) Less than 15 minutes late: Patient will still be seen but not all planned treatment may be provided.
More than 15 minutes late: Counted as missed appointment and no treatment will be provided.

*** In the event we are unable to reach you at your Primary Contact number or email, we will attempt to contact listed alternate numbers. We recommend listing alternate contacts as close relatives or friends who can reach you to help confirm your Dental Appointment. ***

Patient Primary Contact Number: _____

Patient Email Address: _____
(PLEASE PRINT CLEARLY)

Patient Secondary Contact Number: _____

Name/Relationship to Patient: _____

Alternate Contact Number: _____

Name/Relationship to Patient: _____

CONSENT: I understand that *Missouri Highlands Health Care* will use all listed forms of contact in the attempt to communicate with me concerning my dental appointments. I agree to all the terms outlined in this document and acknowledge that it is my sole responsibility to confirm my appointments, arrive on time, and accept the consequences as outlined.

Patient/Guardian Name (Please Print Clearly): _____

Signature: _____ **Date:** _____

MISSOURI Highlands HEALTH CARE

Missouri Highlands Health Care Patient Consent, Authorization & Acknowledgement

Consent to Treatment I hereby grant permission for Missouri Highlands Health Care to perform those procedures and treatments necessary for complete care of myself or a dependent for whom I am legally responsible.

Authorization and Release I authorize Missouri Highlands Health Care to release any information, including the diagnosis and the records of any treatment or examination provided to me or my dependent during the period of such medical care, to third party payers and /or health practitioners. **I authorize and request my insurance company to pay directly to Missouri Highlands Health Care any insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services provided on my behalf or my dependents. If my account balance is sent to an outside agency for collection, I am responsible for collection fees that must be paid to said agency.** I authorize the doctor/dentist/nurse practitioner/behavioral health specialist to perform any treatment, medication administration and therapy that may be indicated in connection with my care or the care of my dependent. I understand that before treatment, full explanation of the procedure(s) involved will be given by staff.

Patient's Rights and Responsibilities We have also shared a copy of our Patient's Rights and Responsibilities, to ensure you are aware of your rights and responsibilities.

Photographic Consent I agree that photographs of me or my dependent may be taken by a member of Missouri Highlands Health Care staff. The photograph(s) will be used for medical records and to help in the avoiding Identity Theft. All photographs are strictly private and the identity of the patient will not be revealed to anyone outside of Missouri Highlands Health Care unless required by law enforcement.

About Our Notice of Privacy Practices We are committed to protecting your personal health information in compliance with the law. 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. If you choose to receive information from Missouri Highlands Health Care via email (e.g. appointment reminders), it will be sent through a secure server. However you will be responsible for the protection of that information once it leaves our server. **Fundraising.** Unless you request us not to, we will use your name and address to support our fund-raising efforts. If you do not want to participate in fund-raising efforts, please mark the following box.

☐ **Please do not use my information for fund-raising purposes.**

Marketing. Unless you request us not to, there are some marketing activities for which we may use your name and address, to provide you with information about services available at our practice. If you'd rather not receive marketing communication from our practice, please mark the following box: ☐ **Please do not use my information for marketing purposes.**

Patient's Name(please print) _____

Patient's Date of Birth_____ Social Security Number _____

Patient/Patient Representative Signature _____

Relationship to Patient _____ Date _____

Witness Signature(MHHC Employee/Representative) _____

This signed consent, authorization and acknowledgement is effective until treatment is terminated in writing by you, the patient, or Missouri Highlands Health Care.

Updated 1/29/2018

MISSOURI Highlands HEALTH CARE

Parent Permission Form

Missouri Highlands Health Care requires the consent of a legal guardian to be present during every appointment for a minor (a child age 17 years & younger). In the event that a legal guardian cannot be present, I consent to allow the parties (an adult 18 years & older) listed below to accompany my child and make medical decisions on my behalf as the situation requires.

Patient Name:_____ Date of Birth_____

Parent/Legal Guardian:_____

1._____

2._____

3._____

4._____

5._____

_____ _____

Parent/Legal Guardian Signature Date

_____ _____

Witness Signature Date