

Dental and Medical History

Patient 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 illness/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

For women ONLY:

YES NO

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)

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

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 Initial

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



Missouri Highlands Health Care PATIENT INFORMATION

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.

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

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, 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-today 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

Check one THEN circle the annual income range on the line beside the household size you have selected.

Household Size	Annual Income Range				
<input type="checkbox"/> 1	<input type="checkbox"/> \$0-14,580	<input type="checkbox"/> \$14,581-19,391	<input type="checkbox"/> \$19,392-24,203	<input type="checkbox"/> \$24,204-29,160	
<input type="checkbox"/> 2	<input type="checkbox"/> \$0-19,720	<input type="checkbox"/> \$19,721-26,228	<input type="checkbox"/> \$26,229-32,735	<input type="checkbox"/> \$32,736-39,440	
<input type="checkbox"/> 3	<input type="checkbox"/> \$0-24,860	<input type="checkbox"/> \$24,861-33,064	<input type="checkbox"/> \$33,065-41,268	<input type="checkbox"/> \$41,269-49,720	
<input type="checkbox"/> 4	<input type="checkbox"/> \$0-30,000	<input type="checkbox"/> \$30,001-39,900	<input type="checkbox"/> \$39,901-49,800	<input type="checkbox"/> \$49,801-60,000	
<input type="checkbox"/> 5	<input type="checkbox"/> \$0-35,140	<input type="checkbox"/> \$35,141-46,736	<input type="checkbox"/> \$46,737-58,332	<input type="checkbox"/> \$58,333-70,280	
<input type="checkbox"/> 6	<input type="checkbox"/> \$0-40,280	<input type="checkbox"/> \$40,281-53,572	<input type="checkbox"/> \$53,573-66,865	<input type="checkbox"/> \$66,866-80,560	
<input type="checkbox"/> 7	<input type="checkbox"/> \$0-45,420	<input type="checkbox"/> \$45,421-60,409	<input type="checkbox"/> \$60,410-75,397	<input type="checkbox"/> \$75,398-90,840	
<input type="checkbox"/> 8	<input type="checkbox"/> \$0-50,560	<input type="checkbox"/> \$50,561-67,245	<input type="checkbox"/> \$67,246-83,930	<input type="checkbox"/> \$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 Dental Appointment Guidelines

Confirming Appointments

All appointments MUST be confirmed no later than 2 business days in advance. MHHC Dental Offices will attempt to contact patients, but it is ultimately the patient's responsibility to confirm their appointment.

*****UNCONFIRMED appointment will be cancelled*****

Missed Appointments

First Missed/Unconfirmed Appointment: Will be rescheduled.

Second Missed/Unconfirmed Appointment: Same-day appointment, when available, will be offered for 6 months.

Third Missed/Unconfirmed Appointment: No appointments will be made for 12 months.

Late Arrival for Appointments

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 Patient Consent, Authorization, and 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 to 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 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.



Missouri Highlands Dental 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 aged 17 years and younger). In the event that a legal guardian cannot be present, I consent to allow the parties (an adult 18 years and 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