MISSOURI Highlands HEALTH CARE

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)

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

Rev. 4/2013

MISSOURI Highlands HEALTH CARE

NEW PATIENT REGISTRATION FORM

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

PATIENT IDENTIFICATION AND CONTACT (Please Print)

Patient Full Name:					
Legal Sex: ☐ Male ☐ Female		**Date of Birth:**		**Social Security #:**	
Residential Address:			**Mailing Address:** ☐ Same		
City:	**State:**	**Zip**	**City**	**State**	**Zip**

Place a check in the box next to the number you prefer to be called first

Home Phone: ☐	**Cell Phone:** ☐	**Work / Alternative Phone:**
Patient Email Address		
Preferred Method of Communication: ☐ Phone Call ☐ Text Message ☐ Email ☐ Letter ☐ Patient Portal		
Missouri Highlands Health Care 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):		

CONTACT and GUARDIAN INFORMATION (If patient is under the age of 17)

Contact below is: ☐ Custodial Parent ☐Legal Guardian ☐ Caretaker ☐ NA	Contact below is: ☐ Custodial Parent ☐Legal Guardian ☐ Caretaker ☐ NA
Guardian Name:	**Guardian Name:**
Guardian Email:	**Guardian Email:**
Home Phone: ☐ Same as Patient **Cell Phone**	**Home Phone:** ☐ Same as Patient **Cell Phone**
Relationship: ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Foster Parent ☐ Grand Parent ☐ Aunt/Uncle ☐ Sibling ☐ Other (Please Specify)	**Relationship:** ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Foster Parent ☐ Grand Parent ☐ Aunt/Uncle ☐ Sibling ☐ Other (Please Specify)

EMERGENCY CONTACT

Name:	**Home Phone:**	**Cell Phone:**
Relationship: ☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ Friend ☐ Cousin ☐ Guardian ☐ Other		

NEXT OF KIN

Name:	**Phone:**	**Relationship:** ☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ Friend ☐ Cousin ☐ Other

DEMOGRAPHICS

Primary Language: ☐English ☐ Spanish ☐ Other (Specify)	**Race (check all that apply):** ☐ White ☐ Black / African American ☐ American Indian / Alaska Native ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Decline to Answer
Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino	**Marital Status:** ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widow ☐ Partner
Gender at Birth: ☐ Male ☐ Female	

MISSOURI Highlands HEALTH CARE

NEW PATIENT REGISTRATION FORM

Agricultural Work (You or a Family Member) This includes work in crop production, animal production, aquaculture, forestry, fishing, or support jobs like planting, picking, feeding, sorting, or caring for farm animals or crops.

☐ Migratory Agricultural Work current or past 2 years and moved from home for this work ☐ Seasonal Agricultural Worker current or past 2 years but DID NOT move from home for this work ☐ Former Migratory Agricultural Worker (Aged or Disabled) stopped work due to age or disability ☐ None of the above apply

Household Size & Annual Income Range: Check the household size **THEN** circle the annual income range on the line beside the household size you have selected.

Household Size			Annual Income Range			
☐	1	→	$0-15,650	$15,651-20,815	$20,816-25,979	$25,980-31,300
☐	2	→	$0-21,150	$21,151-28,130	$28,131-35,109	$35,110-42,300
☐	3	→	$0-26,650	$26,651-35,445	$35,446-44,239	$44,240-53,300
☐	4	→	$0-32,150	$32,151-42,760	$42,761-53,369	$53,370-64,300
☐	5	→	$0-37,650	$37,651-50,075	$50,076-62,499	$62,500-75,300
☐	6	→	$0-43,150	$43,151-57,390	$57,391-71,629	$71,630-86,300
☐	7	→	$0-48,650	$48,651-64,705	$64,706-80,759	$80,760-97,300
☐	8	→	$0-54,150	$54,151-72,020	$72,021-89,889	$89,890-108,300

Housing Status: ☐ Not Homeless ☐ Doubling Up (Staying with others temporarily) ☐ Homeless Shelter ☐ Public Housing (Senior Living / HUD) ☐ Street (Living outdoors, in a car, makeshift shelter) ☐ Transitional (No permanent housing / one place to another) ☐ Other (Hotels/Motels)

Veteran: ☐ Yes ☐ No ☐ Decline to Answer | **Occupation:**

GUARANTOR INFORMATION (To whom statements will be sent)

Guarantor Relation to the patient: ☐ Patient / Self ☐ Child ☐ Spouse ☐ Other (Specify)

Guarantor Full Name: | **Guarantor DOB:**

Guarantor Mailing Address: ☐ Same as patient

City: | **State:** | **Zip:**

Guarantor SSN: | **Guarantor Phone:** | **Guarantor Email:**

Preferred Pharmacy _____ **Location:** _____

PATIENT INSURANCE ☐ Check if uninsured (You will be contacted by a MHHC representative prior to your visit, if checked)

Relation to the Insured: ☐ Patient / Self ☐ Child ☐ Spouse ☐ Other (Specify)

Member ID / Policy #: | **Group #:**

Name of Insured:

Name of Insurance:

MISSOURI Highlands HEALTH CARE

NEW PATIENT REGISTRATION FORM

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I understand that my family members or friends may ask questions about my medical condition over the telephone or in person. I also understand it is a breach of physician-patient confidentiality for any member of my medical care team to discuss my medical information in any way with anyone without expressed written consent. By signing this form, I give Missouri Highlands Health Care permission to discuss my medical information with the people listed below.

I recognize that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I may limit the amount of information that I authorize to be disclosed. It is my expressed wish that ALL medical information may be released. If I have any information that I do not want to give I will list below:

Individual(s) I authorize to receive my medical information:

Name:	**Phone:**	**Relation:**	**DOB:**
Name:	**Phone:**	**Relation:**	**DOB:**

Signature of Patient/Patient Representative _____ **Date** _____ **Signature of MHHC Witness** _____ **Date** _____

MISSOURI Highlands HEALTH CARE

NEW PATIENT REGISTRATION FORM

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 for 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 my medical care team to perform any treatment, medication administration, and/or 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.

SureScripts: I, or my authorized representative, request the health information regarding my care and treatment be released as set forth on this form. In accordance with Missouri State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 *HIPAA), I understand that:

1. BIG SPRINGS MEDICAL ASSOCIATION INC. DBA MISSOURI HIGHLANDS HEALTH CARE uses Surescripts, Inc., a prescription system that allows prescriptions and related information to be exchanged between my medical care team and the pharmacy. The information sent between these systems may include details of all prescription drugs I am currently taking and/or have taken in the past. This information will be utilized by BIG SPRINGS MEDICAL ASSOCIATION INC. DBA MISSOURI HIGHLANDS HEALTH CARE.
2. This authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/or confidential HIV-related information by SureScripts, Inc. to BIG SPRINGS MEDICAL ASSOCIATION INC. DBA MISSOURI HIGHLANDS HEALTH CARE.
3. I have the right to revoke this authorization at any time by writing to BIG SPRINGS MEDICAL ASSOCIATION INC. DBA MISSOURI HIGHLANDS HEALTH CARE. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. My treatment, payment, enrollment, in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be re-disclosed by the recipient, and this re-disclosure may no longer be protected by state or federal law.
6. This authorization expires one year from the date of my signature below.
7. THIS AUTHORIZATION DOES NOT AUTHORIZE BIG SPRINGS MEDICAL ASSOCIATION INC. DBA MISSOURI HIGHLANDS HEALTH CARE TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THOSE PERMITTED UNDER APPLICABLE LAW.

Patient's Rights and Responsibilities: I acknowledge that Missouri Highlands Health Care has shared a copy of their 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 the Missouri Highlands Health Care staff. The photograph(s) will be used for medical records and to help in 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 acknowledgment 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 fundraising efforts. If you do not want to participate in fundraising efforts, please mark the following box:

  ☐ Please do not use my information for fundraising purposes.
- **Marketing** – Unless you request us not to, we will use your name and address for marketing activities, to provide you with information about services available at our practice. If you do not want to receive marketing communications from our practice, please mark the following box:

☐ Please do not use my information for marketing purposes.

Patient Name (please print): _____

_____

Name of Representative/Guardian (If applicable): _____

_____

_____ _____

Signature of Patient/Patient Representative **Date**

_____ _____

_____ _____

Signature of MHHC Witness **Date**

_____ _____

MISSOURI Highlands HEALTH CARE

Missouri Highlands Dental
Appointment Guidelines

_____ **Confirming Appointments**
Initial 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**
Initial 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**
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 _____

Delegation of Another Person to Consent for Treatment of a Minor
Attachment A

I, (parent/legal guardian), _____, cannot accompany my child, (child's name) _____, to Missouri Highlands Health Care, I give permission to the following adult(s) (must be 18 years of age or older):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

I give permission for this person to seek treatment for my child including any type of medical/dental care, diagnostic test, mental health care, immunizations, procedure, and the administration of local anesthesia determined by a Physician, Nurse Practitioner, or Dentist, to be necessary for the welfare of my child, **and provide consent for such treatment if attempts to contact me are unsuccessful.** (initial here) _____

I give permission for this person to seek treatment for my child including any type of medical/dental care, diagnostic test, mental health care, immunizations, procedure, and the administration of local anesthesia determined by a Physician, Nurse Practitioner, or Dentist, to be necessary for the welfare of my child, **and provide consent for such treatment without having to contact me.** (initial here) _____

This form will remain in effect until revoked by filling out the Notice to Revoke Delegation form

This form is VALID ONLY during the following timeframe:

Effective Date: _____ Expiration Date: _____

X_____ _____

(Signature of parent or legal guardian) (Date and Time signed-REQUIRED)

X_____ _____

(Signature of MHHC employee witness) (Date and Time signed-REQUIRED)

Address_____

Home Phone_____ Work Phone_____

Cell Phone_____

Delegation of Another Person to Consent for Treatment of a Minor
Attachment A