ADULT PATIENT REGISTRATION FORM

PATIENTINFORMATION

Name	**Social Security #**	**Gender Preference** ☐ M ☐ F ☐ Transgender (M to F) ☐ Transgender (F to M)	**Date of Birth (MM/DD/YY)**
Primary Address	**City**	**State**	**ZIP**
Alternate Address	**City**	**State**	**ZIP**
Email Address	**Primary Phone**	**Secondary Phone**	
Preferred Contact Method ☐ Mail ☐ Primary Phone ☐ Cell Phone ☐ Portal	**Language Preference**	**Interpreter Needed?** ☐ Yes ☐ No	
Employment Status ☐ Employed ☐ Unemployed	**Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partnership ☐ Separated	**U.S. Citizen?** ☐ Yes ☐ No	**Veteran?** ☐ Yes ☐ No
Race/Ethnicity – Select all that apply. ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White/Caucasian ☐ Other **Are you Hispanic?** ☐ Yes ☐ No	**Type of Housing** ☐ Own ☐ Subsidized ☐ Other Shelter ☐ Rent ☐ Public Housing ☐ Homeless ☐ Staying with Friends/Family		
Emergency Contact Name	**Relationship to Patient**	**Emergency Contact Phone**	

INSURANCE&GUARANTOR INFORMATION

Primary Insurance	**Policy #**	**Group #**	
Subscriber Name	**Relationship to Patient**		
Secondary Insurance (if applicable)	**Policy #**	**Group #**	
Subscriber Name	**Relationship to Patient**		
Guarantor/Name of Person Responsible for Payment (if different from Subscriber)			
Address	**City**	**State**	**ZIP**
Phone	**Relationship to Patient**		

Patient/Guarantor Signature	**Date**

FAMILY Health Source

DENTAL HEALTH HISTORY

Patient Name	Date of Birth (MM/DD/YY)

Do you currently have or have you had any of the following:			
Rheumatic fever or Heart Murmur	☐ Yes ☐ No	Emotional Problems	☐ Yes ☐ No
Heart Trouble	☐ Yes ☐ No	Neurological Problems	☐ Yes ☐ No
High or Low Blood Pressure	☐ Yes ☐ No	Tuberculosis (TB) or Persistent cough	☐ Yes ☐ No
Fainting or Dizzy Spells	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Epilepsy or Seizures	☐ Yes ☐ No
Anemia or Blood Problems	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No
Sickle Cell Anemia	☐ Yes ☐ No	Liver Problems or Hepatitis	☐ Yes ☐ No
Excessive Bleeding or Bruise Easily	☐ Yes ☐ No	Attention Deficit Disorder (ADD)	☐ Yes ☐ No
Blood Transfusions	☐ Yes ☐ No	Hyperactivity Disorder	☐ Yes ☐ No
Allergies or Skin Rash	☐ Yes ☐ No	AIDS or HIV Positive	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Pregnancy (Trimester: ☐ 1 ☐ 2 ☐ 3)	☐ Yes ☐ No
Thyroid Problems	☐ Yes ☐ No		
Cancer (Type: _____)	☐ Yes ☐ No	Other: _____	☐ Yes ☐ No

Are you currently under the care of a physician? If yes, list name of doctor: _____	☐ Yes ☐ No
Have you been hospitalized in the last 2 years? If yes, why? _____	☐ Yes ☐ No
Are you currently taking any medications, pills, or drugs? If yes, list: _____	☐ Yes ☐ No
Are you allergic to or have you ever experienced any ill effect from a local anesthetic (Novocaine), Penicillin, or any drug/pills? (i.e. rash, itching, or fainting) If yes, describe: _____	☐ Yes ☐ No
Have you ever experienced any unfavorable reaction from previous dental treatment? If yes, describe: _____	☐ Yes ☐ No
Are you currently having any dental pain or problem? If yes, describe: _____	☐ Yes ☐ No

Acknowledgement

I certify that I have read and understand the above questions and have answered the questions to the best of my knowledge. I have asked for an explanation of any terms (words) that I did not know (if any), and my questions have been answered to my satisfaction. I will not hold my dentist, or any of his/her staff, responsible for any errors that I may have made in the completion of this form. I also understand that before treatment is provided, I have the right to have the benefits, alternatives, and significant risk factors associated with this treatment explained to my satisfaction.

Patient/Guardian Signature	Relationship to Patient	Date

FAMILY Health Source

DENTAL TREATMENT INFORMATION

Patient Name	Date of Birth (MM/DD/YY)

Dental treatment we offer consists of diagnostic services (examination, x-rays), preventive services (teeth cleaning, fluoride application, sealants, and oral hygiene instructions), corrective restorative services (white fillings, silver crowns), and endodontic services (pulpotomies), usually performed using local anesthetic.

The specific services you need and the availability of these services through this dental program will be explained to you by the dental staff. The services recommended to you are needed to improve and maintain your teeth and supporting structures (gums and bone). Good oral health is needed for eating, speaking, and appearance. Some dental infections may become life-threatening. If you decide to have the recommended treatment, this does not guarantee success, nor does it guarantee that problems will not occur. Success of the treatment also depends on following the home care instructions given to you by the dental staff. Each individual case, however, is unpredictable; your condition may be the same, better, or worse after treatment.

Routine dental treatment has very few risks; they occur rarely and are usually mild. However, you should be aware of these risks, including (but not limited to) complications resulting from the use of dental instruments, drugs (i.e. antibiotic and pain medicine), and local anesthetic. Possible complications include: swelling; sensitivity; bleeding; pain; infection; numbness and/or tingling sensation on the lip, tongue, chin, gums, cheeks, and/or teeth, which is usually temporary but on infrequent occasions may be permanent; chewing injury to the lips and/or tongue after the use of local anesthetic; allergic reaction to any drugs or anesthetic used; change in occlusion (biting); jaw muscle cramps and spasm; temporomandibular (jaw) joint difficulty; loosening of teeth; nausea and vomiting; delayed healing; sinus perforation; and/or treatment failure.

If a complication occurs, additional treatment may be needed. This additional treatment may not be available through Family Health Source. If treatment is not available through this organization, Family Health Source is not financially responsible for the treatment cost associated with taking care of the complication.

It is your responsibility to ask questions about any comments on this sheet that you do not understand so they can be explained to your satisfaction.

Consent for Dental Services – Please initial the statements below.

_____ I certify that I have read and understand the information above.

_____ I authorize and consent to having this procedure performed on the patient indicated at the top of this form by the provider and whomever he or she may designate.

_____ I understand that I may withdraw this consent at any time, in written form.

Patient/Guardian Signature	Relationship to Patient	Date
Employee Signature		**Date**

Sliding Fee Scale Agreement

Patient Name	Date of Birth (MM/DD/YY)

Uninsured patients may qualify for the sliding fee scale discount program at Family Health Source. Eligibility for the sliding fee scale discount program is based on household income and family size. We require documentation to determine eligibility.

Family Health Source reserves the right to review your tax return and/or wage statements upon request. Eligibility will be updated periodically depending on the type of documentation provided. If there are any changes in your income status or insurance eligibility prior to your scheduled update, please notify Family Health Source immediately.

Please initial each statement in the space provided.

_____ *(initials)* I certify that the income and family information supplied on this form is true and correct to the best of my knowledge. I understand that if any of the information provided in this form has been falsified, this agreement will be canceled, and I will be responsible for the **FULL** cost of services. I understand this document will be maintained in my permanent medical record and that falsification of information may constitute a federal offense.

_____ *(initials)* I understand that the sliding fee scale is subject to change.

_____ *(initials)* I understand that payment is expected upon receipt of services.

_____ *(initials)* (If applicable) I have been informed and understand that if I do not supply proof of my income at my next visit, my category will be changed to a higher fee scale.

Patient/Guardian Signature	Relationship to Patient	Date

For Health Center Use Only

Income Verification	Income Source	Amount – Self	Amount – Spouse	Frequency
	☐ Paycheck Stubs – 3 Most Recent			☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually
	☐ Social Security Benefits Determination			☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually
	☐ Last Year's Income Tax Return			☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually
	☐ Unemployment Compensation Statement			☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually
	☐ Notarized Letter of Support			☐ Monthly ☐ Quarterly ☐ Semiannually ☐ Annually
	☐ Other Income			☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually

Total Members in Household*: _____ **For 3 or more household members, please produce last year's tax return.*

☐ Your documented annual income is $_____. Your documented family size is _____.

Therefore, you qualify for the Sliding Fee Schedule noted below until _____.

☐ No proof of income presented – One-time exemption used. Indicate appropriate Sliding Fee Schedule below.

☐ SLIDE A	☐ SLIDE B	☐ SLIDE C	☐ SLIDE D	☐ SLIDE E	☐ SLIDE F

Employee Signature	Employee Title	Date

Authorization and Agreement for Treatment

Patient Name	Date of Birth (MM/DD/YY)

The undersigned hereby makes the acknowledgements and agreements regarding the treatment to be provided to the patient whose name appears on the Registration Form. The patient, guardian, or patient representative must initial all applicable items.

Consent for Treatment

_____ *(initials)* I certify that I am requesting examination and medical treatment of the patient by the physicians and employees of Family Health Source. I give permission for evaluation and treatment and certify that no guarantee or assurance has been made as to the results that may be obtained. If the patient is a minor, I understand that a parent, legal guardian, or responsible adult must accompany the patient to the health center and stay with the patient throughout the entire examination.

Financial Agreement and Assignment of Benefits

_____ *(initials)* I acknowledge that I have received a copy of the Family Health Source Financial Policy and that I agree to abide by its terms.

Patient's Bill of Rights and Responsibilities

_____ *(initials)* I acknowledge that I have received a copy of the Family Health Source Patient's Bill of Rights and Responsibilities and that I agree to abide by its terms.

Notice of Privacy Practices

_____ *(initials)* I acknowledge that I have received a copy of Family Health Source's Notice of Privacy Practices.

Release of Medical Information

_____ *(initials)* (If applicable) In addition to the use and/or disclosure of my PHI as stated above, I authorize my information to be released to the following individual(s). Please provide full name(s) of authorized individual(s) below. I understand that this request will not restrict the normal use or disclosure of PHI as stated above.

Name of Authorized Person	Relationship to Patient

_____ *(initials)* I understand that I may amend or revoke my consent to use and/or disclosure of PHI at any time, if submitted in writing. Use or disclosure that occurs prior to the date on which the revocation of consent is received will not be affected.

I have read and fully understand the above acknowledgments and agreements.

Patient/Guardian Signature	Relationship to Patient	Date

For Health Center Use Only		
Employee Signature	**Employee Title**	**Date**