PATHS
Live Life. Be Healthy.
Community Dental Center

Today's Date: ___ / ___ / _____

A. Patient Information

Name: _____ Birth Date: ___ / ___ / _____ Gender: ❒ Male ❒ Female

Social Security Number: _____ - ____ - _____ Phone (H): (_____) _____ - _____ Phone (Alternate): (_____) _____ - _____

Address: _____ City: _____ ST: ___ Zip: _____

Marital Status: ❒ Single ❒ Married ❒ Separated ❒ Divorced ❒ Widowed

Race:
❒ African American ❒ White ❒ Hispanic ❒ Asian ❒ Native American ❒ Filipino ❒ Pacific Islander
❒ Other: _____

Employer (or Name of School if Minor): _____

Work Address: _____ City: _____ ST: ___ Zip: _____

Spouse or Guardian's Name: _____ Phone: (____) ____ - _____

Emergency Contact: _____ Phone: (____) ____ - _____

B. Responsible Party

Name of Person Responsible for this Account: _____ Phone: (____) ____ - _____

Relationship to Patient: _____ Date of Birth: ___ / ___ / _____

Address: _____ City: _____ ST: ___ Zip: _____

Is this person also a patient at PATHS Community Dental Clinic? ❒ Yes ❒ No

For your convenience, we offer the following methods of payment. Check the option you prefer. Payment in full is expected when services are rendered.

❒ Cash ❒ Personal Check ❒ Visa ❒ MasterCard ❒ I wish to discuss other payment options

C. Insurance Information

Primary Insurance:

Name of Insured: _____ Relationship to Patient: _____Date of Birth: ___ / ___ / _____

SS#: ____ - ___ - _____ Insurance Company: _____ Address: _____

Employer: _____ Address: _____ City: _____ ST: ___ Zip: ____

Group #: _____ Policy #: _____

D. Authorizations & Releases

Payment is due in full at the time of treatment unless prior arrangements have been approved. This office accepts insurance. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductibles that my insurance does not cover. I hereby authorize payment directly to PATHS Community Dental Clinic of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize PATHS Community Dental Clinic to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

I authorize PATHS Community Dental Center, a division of Piedmont Access To Health Services, Inc. (PATHS), through its appropriate personnel and/or staff to perform, administer, or prescribe upon me, or any member of my family (including minor children) whose name appears above, such examination, injections and diagnostic procedures that are deemed necessary.

I understand that Virginia law requires health care providers to notify me that Hepatitis B and C or HIV (AIDS virus) testing on a sample of your blood may be done if a health care worker is exposed to your blood or body fluids. This following notice is to advise me that this is in effect at this facility. Under the Virginia Acts of Assembly Section 32.1-45.1, whenever any health care worker associated with or working for the PATHS Community Dental Center is directly exposed to body fluids of a patient in a manner which, according to the guidelines of the Centers for Disease Control, may transmit HIV or Hepatitis B or C, PATHS will proceed to test the patient's blood for HIV and Hepatitis B and C. PATHS will provide the results of the test to the patient through his or her primary care provider and to the health care worker who was exposed. PATHS policy also protects me as a patient, should I be exposed to the body fluids of a health care worker.

Patient/Guardian's Signature: _____ Date: ___ / ___ / _____

E. Patient Dental History

Previous Dentist Name: _____ Date of Last Exam: ___ / ___ / _____

❒ Yes ❒ No 1. Do your gums bleed while brushing or flossing?
❒ Yes ❒ No 2. Are your teeth sensitive to hot or cold?
❒ Yes ❒ No 3. Are your teeth sensitive to sweet or sour?
❒ Yes ❒ No 4. Do you feel pain in any of your teeth?
❒ Yes ❒ No 5. Do you have any sores or lumps in or near mouth?
❒ Yes ❒ No 6. Have you had any head, neck, or jaw injuries?

7. Have you ever experienced any of the following in your jaw:
   - ❒ Yes ❒ No a. Clicking
   - ❒ Yes ❒ No b. Pain (joint, ear, side of face)
   - ❒ Yes ❒ No c. Difficulty in opening or closing
   - ❒ Yes ❒ No d. Difficulty chewing

❒ Yes ❒ No 8. Do you have frequent headaches?
❒ Yes ❒ No 9. Do you clench or grind your teeth?
❒ Yes ❒ No 10. Do you bite your lips or cheeks?
❒ Yes ❒ No 11. Have you ever had a difficult extraction?
❒ Yes ❒ No 12. Have you ever had any prolonged bleeding following extractions?
❒ Yes ❒ No 13. Have you had any orthodontic treatment?
❒ Yes ❒ No 14. Do you wear dentures or partials? If yes, date of placement: ___ / ___ / _____
❒ Yes ❒ No 15. Have you ever received instructions regarding the care of your teeth & gums?
❒ Yes ❒ No 16. Do you like your smile?

F. Patient Medical History:

Primary Care Physician: _____ Phone: (_____) ____ - _____ Date of Last Visit: ___ / ___ / _____

❒ Yes ❒ No 1. Are you currently under medical treatment for any condition?
❒ Yes ❒ No 2. Have you been hospitalized for any surgical operation or illness within the past 5 years?
❒ Yes ❒ No 3. Are you taking any medications (prescribed or over the counter)? If yes, what are they: _____
_____
_____
❒ Yes ❒ No 4. Have you ever taken Fen-Phen/Redux?
❒ Yes ❒ No 5. Have you ever taken Fosamax, Boniva, Actoinel, or any cancer medications containing bisphosphonates?
❒ Yes ❒ No 6. Have you taken Viagra, Revati, Cialis, or Levitra in the last 24 hours?
❒ Yes ❒ No 7. Do you use tobacco?
❒ Yes ❒ No 8. Do you use controlled substances?
❒ Yes ❒ No 9. Are you wearing contact lenses?
❒ Yes ❒ No 10. Do you have a persistent cough/throat clearing not associated with known illness?

11. Are you allergic, or had reactions to any of the following:

❒ Yes ❒ No Asprin	❒ Yes ❒ No Erythromycin	❒ Yes ❒ No Percocet
❒ Yes ❒ No Benzocaine	❒ Yes ❒ No Fluoride	❒ Yes ❒ No Prophy Paste
❒ Yes ❒ No Cipro	❒ Yes ❒ No Food	❒ Yes ❒ No Seasonal Allergies
❒ Yes ❒ No Clindamycin	❒ Yes ❒ No Iodine	❒ Yes ❒ No Sulfa
❒ Yes ❒ No Codeine	❒ Yes ❒ No Latex	❒ Yes ❒ No Tetrocycline
❒ Yes ❒ No Darvocet	❒ Yes ❒ No Local Anesthetic	❒ Yes ❒ No Tylenol
❒ Yes ❒ No Epinephrine	❒ Yes ❒ No Penicillin	❒ Yes ❒ No Z-pak

12. Do you have, or have you had any of the following?

❒ Yes ❒ No ADD/ADHD	❒ Yes ❒ No Endometriosis	❒ Yes ❒ No HIV
❒ Yes ❒ No Anemia	❒ Yes ❒ No Epilepsy/Seizures	❒ Yes ❒ No Hormone Therapy
❒ Yes ❒ No Angina	❒ Yes ❒ No Excessive Bleeding	❒ Yes ❒ No Jaundice
❒ Yes ❒ No Arthritis	❒ Yes ❒ No Fibromyalgia	❒ Yes ❒ No Kidney Disease
❒ Yes ❒ No Artificial Joints	❒ Yes ❒ No General Allergies	❒ Yes ❒ No Liver Disease
❒ Yes ❒ No Asthma (Use Inhaler)	❒ Yes ❒ No Glaucoma	❒ Yes ❒ No Lupus
❒ Yes ❒ No Asthma (No Inhaler)	❒ Yes ❒ No Growths	❒ Yes ❒ No Menopause
❒ Yes ❒ No Back/Spine Injury	❒ Yes ❒ No Hay Fever	❒ Yes ❒ No Mental Disorder
❒ Yes ❒ No Blood Disease	❒ Yes ❒ No Heart Disease/Problem	❒ Yes ❒ No Migraines
❒ Yes ❒ No BPH/Prostate Health	❒ Yes ❒ No Hepatitis	❒ Yes ❒ No Mitral Valve Prolapse
❒ Yes ❒ No Cancer: _____	❒ Yes ❒ No Herpes	❒ Yes ❒ No Neurological Disorder
❒ Yes ❒ No Diabetes	❒ Yes ❒ No High Blood Pressure	❒ Yes ❒ No Pregnancy
❒ Yes ❒ No Dizziness/Fainting Spells	❒ Yes ❒ No High Cholesterol	❒ Yes ❒ No Stroke
		❒ Yes ❒ No T.B.

❒ Yes ❒ No 13. Women Only: Are you pregnant, or think you may be pregnant?
❒ Yes ❒ No 14. Women Only: Are you nursing?
❒ Yes ❒ No 15. Women Only: Are you taking oral contraceptives?

I give the dentist and/or hygienist permission to use local anesthetic as needed: ❒ Yes ❒ No

By signing below, I certify that I have read and understand the above Medical History questionnaire. I understand that this information will be used by PATHS Community Dental Clinic staff to help determine appropriate and healthful dental treatment. If there are any changes in my medical status, I will inform PATHS Community Dental Clinic immediately.

Patient/Guardian Signature: _____ Date: ___ / ___ / _____

G. Acknowledgement of Receipt of Privacy Practices

Our "Notice of Privacy Practices" contains information on how we may use and disclose information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may request a reviewed copy.

By signing the line below, you certify that you have been provided a copy of the Notice of Privacy Practices for PATHS Community Dental Clinic, and that you understand you may ask questions regarding this notice if I do not understand any of the information contained therein.

Please list anyone that you authorize us to release information to:

Spouse: _____ ❒ In Person ❒ By Phone

Other: _____ ❒ In Person ❒ By Phone

Other: _____ ❒ In Person ❒ By Phone

Patient/Guardian's Signature: _____ Date: ___ / ___ / _____

H. Application for Financial Assistance

This information needs to be completed <u>ONLY</u> by those seeking to apply for financial assistance/sliding scale.

Number of people living in the same household (including yourself): _____

List everyone, other than yourself, below:

Name (First, MI, Last)	*Relationship to Patient*	*DOB*	*Also a patient here?*
_____	_____	___/___/_____	❒ Yes ❒ No
_____	_____	___/___/_____	❒ Yes ❒ No
_____	_____	___/___/_____	❒ Yes ❒ No
_____	_____	___/___/_____	❒ Yes ❒ No
_____	_____	___/___/_____	❒ Yes ❒ No

Please itemize your gross (before taxed) income below.

Salary Wages (self):	_____	Social Security Income:	_____
Salary Wages (others):	_____	SSI Income:	_____
Interest on Savings Accounts:	_____	Pension/Annuities/Retirement Income:	_____
Dividends from Investments:	_____	Welfare:	_____
Personal Business Profits:	_____	Aid to Dependent Children:	_____
Rental Income:	_____	Disability/Other Insurance Income:	_____
Unemployment Payments:	_____	Veteran's Benefit Payments:	_____
Alimony:	_____	Other Income: _____	_____
Child Support:	_____	Other Income: _____	_____

TOTAL Income: _____ ❒ Weekly ❒ Monthly ❒ Annually

By signing below, I certify that the information I have given concerning the size of my family and my family's gross income from all sources is true, accurate, and complete to the best of my knowledge. I understand PATHS Community Dental Clinic will rely on such information to determine the discount amount that will be offered to me. I realize that knowingly giving false information in this case may result in criminal prosecution under Virginia state laws. I agree to report any change in either my income or family size to PATHS Community Dental Clinic. I know that the information I have given will continue to be relied upon until it is changed. If PATHS Community Dental Clinic has reason to suspect that the information I have given is untrue, incomplete, or inaccurate, or that I have not properly reported changes, the Clinic may initiate a review of my pap status and I will authorize access to my family records. If I refuse such reviewer authorization, the Clinic will no longer discount my account. I have been told that I must furnish proof of income upon my initial dental appointment.

Patient/Guardian Signature: _____ Date: ___ / ___ / _____