Douglas County Health Department and Dental Clinic

REGISTRATION FORM

(Please Print)

Today's date:

RESPONISIBLE PARTY INFORMATION

Responsible Party's Last Name: **First**: **M.I.:** ❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms. **Marital status** (circle one) Single / Mar / Div / Sep / Wid

Race (Optional): ❍ White ❍Native American ❍Other/ Unknown ❍Asian/Pacific Islander ❍ African American/ Black **Ethnicity** (Optional): ❍Hispanic ❍Non-Hispanic **Date of Birth:** / / **Age**: **Sex**: ❍ M ❍ F

Street address: **Drivers License Number:**

P.O. Box: **City:** **State:** **ZIP Code:**

Primary Phone Number: ( ) - **Secondary Phone Number:** ( ) - **Medicaid Number:**

Responsible Party's Relationship to Patient:
❍Self ❍Spouse ❍Parent ❍Other/_____

PATIENT INFORMATION

Patient's Last Name: **First:** **M.I.:** **Date of Birth:** / / **Age:** **Sex:** ❍M ❍F

Race(Optional): ❍White ❍Native American ❍Other/Unknown ❍Asian/Pacific Islander ❍African American/Black **Ethnicity** (Optional): ❍Hispanic ❍Non-Hispanic **Medicaid Number:**

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): **Relationship to patient:** **Primary Phone Number** ( ) -

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Updated August 2013

Douglas County Health Department

Acknowledgment of Notice of Privacy Practices

My signature below indicates that I have been given an opportunity to read the Notice Of Privacy Practices for the *Douglas County Health Dept* and to have any questions answered before signing.

Signed: _____ Date: _____

Print Name: _____

If signed by someone other than the patient, please indicate relationship to patient:

[ ] Parent or guardian of minor patient

[ ] Guardian or conservator of an incompetent patient

[ ] Beneficiary or personal representative of deceased patient

FOR OFFICE USE ONLY:

Employee Signature: _____ Date_____

If patient or patient's representative refuses to sign this Acknowledgment:

[ ] Efforts to Obtain: _____

[ ] Reason patient refused to sign: _____

THE FOLLOWING POLICIES ARE IMPORTANT TO ALLOW US TO PROVIDE YOU WITH THE BEST POSSIBLE DENTAL CARE AND COMPLETE YOUR TREATMENT IN A TIMELY MANNER

- Please have a current insurance card and valid identification (driver's license) at EACH visit.

- Our goal is to help you have good oral health. Therefore, we require each patient receive a dental cleaning and x-rays from a dental hygienist before beginning any treatment with the dentist. (ADULT CLEANINGS ARE NOT COVERED BY IL DEPT. OF PUBLIC AID MEDICAL INSURANCE)

- It is important that you follow the dental staff's care instructions between visits.

- Your hygienist will discuss with you the importance of regular visits to our clinic (usually every 6 months) for a cleaning and examination. THESE VISITS WILL HELP PREVENT PAINFUL DENTAL PROBLEMS IN THE FUTURE.

- Please arrive 10 minutes before your appointment to allow us to check you in. In order to respect our other patients, you may be rescheduled to a later date if you arrive past your appointment time. We will strive to see you at your appointment time, except where other emergency or problem cases interfere.

- **24 HOUR NOTICE PRIOR TO CANCELLATION IS REQUIRED**. After the **FIRST** missed appointment there will be a 6 month waiting period before scheduling a second appointment. After **TWO** missed appointments by an individual/family, you will be required to pay a **$20** reinstatement fee before receiving any treatment at your next appointment. A **THIRD** failed appointment will prevent you from receiving dental treatment in our clinic. You will receive notification by mail if we find it necessary to take this action. We reserve the right to decide if this policy can be waived for special situations.

I understand the above listed policies and accept my responsibility to follow them in order to have a successful dental health partnership with Douglas County Health Department Dental Clinic.

NAME_____ **DATE**_____

PATIENTS RIGHTS AND RESPONSIBILITIES

PATIENT RESPONSIBILTIES

As a patient, you are responsible for:

- Healthy dental habits – BRUSHING, FLOSSING, AND REGULAR DENTAL VISITS
- Providing all information about you and/or your child's health history
- Working with the dental providers to carry out agreed-upon treatment plan
- Clearly communicate to the dental staff your wants and needs
- Following all instructions about your care given by the dental staff
- Realize the risks and limits of dentistry
- Be aware that the dental clinic must provide equal care to other patients
- Showing respect to other patients and personnel
- Paying amount due at the time of service
- Following clinic rules including scheduling and cancellation policies

PATIENT RIGHTS

As a patient, you have to right to:

- Fair and respectful care from every staff member
- Easily understood information about the dental health of you and/or your child, clinic policies, including payment policies
- If English is not your native language, if you have a physical or mental disability, or if you do not understand something, assistance will be provided so you can make informed decisions
- Know the names and positions of all staff members involved in the care of you and/or your child
- Receive care from properly licensed dentists and hygienists
- Know the treatment choices, and the risk and benefits of each choice
- Decline treatment, and to receive an explanation if the dentists decides to decline treatment
- To have the health care information of you and/or your child protected.