



**DENTAL PAPERWORK**

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**PATIENT INFORMATION**

First Name	M.I.	Last Name
Social Security Number		Date of Birth
Birth Sex (Check one)	Female	Male
Billing Address		
City	State	Zip
Physical Address (if different than above)		
City	State	Zip

**CONTACT INFORMATION**

May We Leave Detailed Messages (Appointments, Billing, Results, etc.)?

Home Phone	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Cell Phone	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Work Phone	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Email Address				

**EMERGENCY CONTACT**

Name	Relationship	Phone #
Name	Relationship	Phone #

**HIPAA - DISCLOSURE TO FAMILY AND FRIENDS**

Please list anyone allowed to be given your medical & billing information:

1	
2	
3	

Your information will not be released by telephone or in person to any not on this list.



**BILLING INFORMATION**

Person Responsible for Bill		Relationship to Patient	
Address		Date of Birth	
City	State	Zip	
Occupation	Employer	Phone #	

**PRIMARY DENTAL INSURANCE**

Name of <b>Primary</b> Insurance		Subscriber's Name	
Subscriber's Date of Birth	Subscriber's SSN	Phone #	
Policy #		Group #	

**SECONDARY DENTAL INSURANCE**

Name of <b>Secondary</b> Insurance		Subscriber's Name	
Subscriber's Date of Birth	Subscriber's SSN	Phone #	
Policy #		Group #	

**PHARMACY INFORMATION**

Name	City
------	------



## REQUIRED FQHC DEMOGRAPHICS

We are required to ask all patients the following.

**1. Marital Status:**

- Single
- Married
- Divorced
- Separated
- Widowed
- Choose Not to Disclose

**2. Medical Insurance:**

- Commercial
- Dual (Medicare and Medicaid)
- Medicare
- Medicaid
- Sliding Fee
- None/Uninsured

**3. Agriculture Worker:**

- Migrant Agriculture Worker
- Not a Farm Worker
- Seasonal Agriculture Worker

**4. Race:** (Select All That Apply)

- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian
- Native Hawaiian
- Other Pacific Islander
- Guamanian or Chamorro
- Samoan
- Black/African American
- American Indian/Alaska Native
- White
- Choose Not to Disclose

**5. Ethnicity:**

- Mexican, Mexican American, Chicano/o
- Puerto Rican
- Cuban
- Another Hispanic, Latino/a, or Spanish Origin
- Not Hispanic or Latino
- Choose Not to Disclose

**6. Preferred Language:**

- English
- Spanish
- Other: \_\_\_\_\_
- Choose Not to Disclose

**7. Housing Status:**

- Not Homeless
- Doubling Up
- Homeless Shelter
- Permanent Supportive Housing
- Street
- Transitional
- Other
- Unknown

**8. Veteran Status:**

- Yes
- No

**9. Gender Identity:**

- Female
- Male
- Transgender Female
- Transgender Male
- Other
- Choose Not to Disclose

**10. Sexual Orientation:**

- Straight or Heterosexual
- Lesbian, Gay, or Homosexual
- Bisexual
- Other
- Don't Know
- Choose Not to Disclose

**11. Family Size and Income**

Family Size (Self + Dependents)
Annual Income for Family
<input type="checkbox"/> Choose Not to Disclose



## PATIENT'S ACKNOWLEDGMENT AND CONSENT

### BILLING ACKNOWLEDGMENT

Please initial in the box below after reading.

	As a courtesy, SEMO Health Network will file your insurance claim provided that you have given us the current/valid information about your insurance. I hereby authorize my benefits, including Medicare, to be paid directly to SEMO Health Network and also the release of medical information necessary to process claims. This assignment will remain in effect until revoked by me in writing. Applicable co-payments and deductible for those insurance plans will be collected. If insurance does not pay, I will become financially responsible for payment in full.
--	--

### PRIVACY ACKNOWLEDGMENT

Please initial in the four boxes below after reading.

	<b>We are required to protect your privacy.</b> Our Notice of Privacy Policy (NPP) details your rights as a patient and how we may use and/or disclose your protected health information. Our NPP is Available on our website at <a href="http://www.semohealthnetwork.org">www.semohealthnetwork.org</a> and/or is furnished.
	<b>We request all patients present photo ID and their insurance card at each visit.</b> Your cooperation with this HIPAA requirement is designed to protect your identity from misuse.
	<b>HIPAA Security Rule establishes national standards to protect your health</b> You will need required personal information when calling our office regarding question's to your account.
	<b>Patients may revoke or change any provided authorizations at any time.</b>  Please refer to our NPP at <a href="http://www.semohealthnetwork.org">www.semohealthnetwork.org</a> for more details.

### CONSENT FOR TREATMENT

<p><b>Consent for Treatment – ADULT:</b> By signing below I am giving consent to receive treatment or procedure deemed necessary by the professional staff of SEMO Health Network, including any Telehealth visit or other use of electronic means (such as FaceTime), to see my provider. I understand all the</p>	
<p><b>Consent for Treatment – CHILD or INCAPACITATED ADULT:</b> By signing below I hereby state that I am the parent, primary legal guardian, or joint legal custodian of the patient being presented today for treatment. I also am giving my consent as guardian for any treatment or procedure deemed necessary by the professional staff of SEMO Health Network, including any Telehealth visit or other use of electronic means (such as FaceTime), to see their provider. I understand all the preceding statements and will</p>	
<p>_____</p> <p><b>Print Name of Patient</b></p>	
<p>_____</p> <p><b>Patient/Legal Guardian Signature</b></p>	<p>_____</p> <p><b>Date</b></p>
<p><b>QA APPROVED APRIL 2023</b></p>	



## **No-Show Policy for SEMO Health Network**

**Purpose:** To guide the management of Dental/Medical patients who do not keep appointments, cancel without sufficient notice (**defined as less than 24 hours**) or show up more than **15 minutes late** for their scheduled appointments.

### **Procedure:**

1. All new and existing patients of Dental/Medical at SEMO Health Network will be given a written copy of the No-Show Policy and be required to sign an acknowledgment of the policy that will be scanned in the EMR (electronic medical record).
2. Scheduled appointments will be confirmed the day before. (Patients are still responsible for their scheduled appointment regardless of a successful or unsuccessful reminder).

**Cancelling Appointments:** If you cannot keep your scheduled appointment, you must call **24 hours** in advance to cancel or reschedule. Failure to provide 24 hours' notice is considered a No-Show.

**No-Show Appointments:** No show appointments are taken very seriously and will be documented in the EMR. Following the third (3<sup>rd</sup>) no-show appointment you will not be able to schedule an appointment, you will be placed on a "work-in" only status. (**Medical**): Work-in appointments will be allowed to come in at 8:15am-10:00am and will be worked in only if the schedule allows. If you were unable to be seen in the morning then the work-in schedule will open at 12:45pm-3:00pm. (**Dental**): Work-in appointments will be allowed to come in at 7:30am-10:00am and will be worked in only if the schedule allows. If you were unable to be seen in the morning then the work-in schedule will open at

12:30pm-3:00pm. Being placed on the work-in schedule does not guarantee that you will be seen that day or by your Provider. After you have been seen three (3) times on the work-in schedule then you will be allowed to schedule your next appointment.

Please discuss with any Dental/Medical staff if you have any questions regarding the No-Show Policy.

I understand and agree to abide by this No-Show Policy.

---

Patients Signature

---

Date

---

Parent/Guardian Signature (for patient under 18)

---

Date

**ALL NO SHOW APPOINTMENTS WILL BE TRACKED THROUGH OUR ELECTRONIC MEDICAL RECORDS!**

QA Approved June 2018

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

<b>Patient Name</b>		<b>Date of Birth</b>					
<b>Primary Care Provider</b>		<b>Smoking Status</b> (Please Check)	<input type="checkbox"/> Current Smoker	<input type="checkbox"/> Non-Smoker			
			<input type="checkbox"/> Previous Smoker	<input type="checkbox"/> Other			
<b>Current Medications:</b>							
(Please include all over the counter meds or supplements)							
<b>Allergies/Reaction</b>							
(Please Circle)	Amoxicillin/Pencillin	Codeine	Latex	Local Anesthetic	Iodine	Metals	Sulfa
	Dental Materials	Aspirin	Other:			No Known Allergies	

**Past Medical/Surgical History**

<b>Medical History</b> (Circle all that apply)	Abnormal Bleeding	ADD/ADHD	Alcohol Abuse	Anemia
	Angina Pectoris	Anxiety	Arthritis	Artificial Heart Valve
	Asthma	Autism	Blood Clotting Disorder	Blood Transfusion
	Cancer	Chemotherapy	Cognitive Disability	Congenital Heart Defect
	Constipation	COPD	Depression	Diabetes
	Difficulty Breathing	Drug Abuse	Eczema	Emphysema
	Fainting	Fever Blisters	Food Allergies	Frequent Headaches
	Glaucoma	HIV/AIDS	Heart Attack	Heart Murmur
	Hemophilia	Hepatitis C	High Blood Pressure	Joint Replacement
	Kidney Problems	Liver Disease	Low Blood Pressure	Mitral Valve Prolapse
	Pacemaker	Prematurity	Psychiatric Problems	Radiation Therapy
	Recurrent Earaches	Recurrent Strep	Rheumatic Fever	Seasonal Allergies
	Seizures	Shingles	Sickle Cell Disease	Sinus Problems
	STDs	Stroke	Thyroid Problems	Ulcers
	UTI	Vision Problems	Wheezing	Other:

<b>Surgical History</b> (Circle all that apply)	Adenoidectomy	Appendectomy	Ear Tubes	Fundoplication
	Gastrostomy Tube	Heart Surgery	Hernia Repair	Joint Replacement
	Tonsillectomy	Urologic Surgery	VP Shunt	Other:

<b>General Health:</b>	1. Are you in good health?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	2. Have there been any changes to your health in the last year?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	3. Have you had any serious illness, operation, or been hospitalized in the past five years?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	If yes, please describe. _____		
	4. Have you had a total joint replacement?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	If yes, when? _____		
	If yes, what joint? _____		

<b>General Health :</b>	5. Has a doctor ever told you to take antibiotics before dental treatment?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	6. Have you ever taken IV bisphosphonates? (Boniva, Fosamax)	<input type="checkbox"/> YES	<input type="checkbox"/> NO

<b>Women Only:</b>	1. Are you or could you be pregnant?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	2. Are you breastfeeding?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

**Dental and Lifestyle History Form**

<b>Lifestyle</b>	1. Do you have any physical or mental disabilities that may require special care such as hearing, sight, or speech impairments? If yes, please describe: _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	2. Do you drink alcohol? If yes, please list amount and frequency: _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	3. Do you smoke or use tobacco? If yes, please list type and frequency: _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	4. Do you use any street drugs? If yes, please list type and frequency: _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO

<b>Dental History</b>	1. What is your reason for seeking care today? _____ _____		
	2. Do you have regular dental checkups?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	3. Date of last exam: _____		
	4. Have you had any trouble with previous dental treatment? If yes, please describe: _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	5. How do you care for your teeth? _____ _____		
	6. Has fear ever prevented you from seeking dental care?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	7. Do your gums bleed when you brush your teeth?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	8. Do you have lumps or sores in your mouth?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	9. Do you suffer from pain in the mouth, face, eyes, neck, or throat?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	10. Do you ever have pain, clicking, or popping in your jaw (TMJ)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	11. Are you happy with the appearance of your teeth?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	12. Do you want to save your teeth?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	13. Do you feel that you have dry mouth?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	14. Do you eat or drink sugary foods or drinks?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	15. Have you ever injured your face, jaws, or teeth?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

<b>Previous Treatment</b>				
(Please circle all that apply)	Fillings	Orthodontics (Braces)	Oral Surgery (Extractions)	Gum Treatment
	Root Canals	Dentures	Implants	TMJ Treatment

**I affirm that this record is true and accurate to the best of my knowledge.**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

**Relationship to patient**  
(Please circle)

Self                      Parent/Guardian