SEMO HEALTH NETWORK

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	☐	Yes	☐	No
Cell Phone	☐	Yes	☐	No
Work Phone	☐	Yes	☐	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.

SEMO HEALTH NETWORK

BILLING INFORMATION

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

PRIMARY DENTAL INSURANCE

Name of **Primary** Insurance		Subscriber's Name
Subscriber's Date of Birth	Subscriber's SSN	Phone #
Policy #		Group #

SECONDARY DENTAL INSURANCE

Name of **Secondary** Insurance		Subscriber's Name
Subscriber's Date of Birth	Subscriber's SSN	Phone #
Policy #		Group #

PHARMACY INFORMATION

Name	City

SEMO HEALTH NETWORK

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
☐ Choose Not to Disclose

SEMO HEALTH NETWORK

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.

	We are required to protect your privacy. 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 www.semohealthnetwork.org and/or is furnished.
	We request all patients present photo ID and their insurance card at each visit. Your cooperation with this HIPAA requirement is designed to protect your identity from misuse.
	HIPAA Security Rule establishes national standards to protect your health You will need required personal information when calling our office regarding question's to your account.
	Patients may revoke or change any provided authorizations at any time. Please refer to our NPP at www.semohealthnetwork.org for more details.

CONSENT FOR TREATMENT

Consent for Treatment – ADULT: 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

Consent for Treatment – CHILD or INCAPACITATED ADULT: 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

Print Name of Patient

Patient/Legal Guardian Signature **Date**

QA APPROVED APRIL 2023

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 (3rd) 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

SEMO HEALTH NETWORK

Date: _____/_____/_____

Patient Name	**Date of Birth**
Primary Care Provider	**Smoking Status** (Please Check) ☐ Current Smoker ☐ Non-Smoker ☐ Previous Smoker ☐ Other

Current Medications: _____

(Please include all over the counter meds or supplements) _____

_____

_____

Allergies/Reaction (Please Circle)

Amoxicillin/Pencillin | Codeine | Latex | Local Anesthetic | Iodine | Metals | Sulfa

Dental Materials | Aspirin | Other: | No Known Allergies

Past Medical/Surgical History

Medical History (Circle all that apply)

Abnormal Bleeding	ADD/ADHD	Alcohol Abuse	Anemia
Angina Pectoris	Anxiety	Arthritis	Artifical 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:

Surgical History (Circle all that apply)

Adenoidectomy	Appendectomy	Ear Tubes	Fundoplication
Gastrostomy Tube	Heart Surgery	Hernia Repair	Joint Replacement
Tonsillectomy	Urologic Surgery	VP Shunt	Other:

General Health:

1. Are you in good health? ☐ YES ☐ NO
2. Have there been any changes to your health in the last year? ☐ YES ☐ NO
3. Have you had any serious illness, operation, or been hospitalized in the past five years? ☐ YES ☐ NO

   If yes, please describe. _____
4. Have you had a total joint replacement? ☐ YES ☐ NO

   If yes, when? _____

   If yes, what joint? _____

General Health :	5. Has a doctor ever told you to take antibiotics before dental treatment?	☐ YES	☐ NO
	6. Have you ever taken IV bisphosphonates? (Boniva, Fosamax)	☐ YES	☐ NO

Women Only:	1. Are you or could you be pregnant?	☐ YES	☐ NO
	2. Are you breastfeeding?	☐ YES	☐ NO

Dental and Lifestyle History Form

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

Dental History

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

Previous Treatment

(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

PARENT PERMISSION FORM

In the event that you are unable to bring your child for an appointment, SEMOHN requires your permission for another adult to bring your child into our clinics for Dental treatment. Please keep in mind that ONLY the persons listed will be able to sign for your child.

Parent Name	Relationship
Parent Name	Relationship
Legal Guardian (if different from parents)	

Please list any other adult below that has permission to bring and sign for your child.

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship

By signing below, I am acknowledging that I have completed the above information to the best of my knowledge. I have read and understood the above information.

Patient/Legal Guardian Signature **Date**