THE SALVATION ARMY DOING THE MOST GOOD

DENTAL CENTER

PLEASE FILL OUT AND RETURN AS SOON AS POSSIBLE

Dear Parent/Guardian,

Please check the following services that you permit your child to have administered at the Oil City High School Dental Suite:

____ Exam

____ Digital x-rays

____ Prophylaxis

____ Fluoride Treatment

____Sealants

_____ _____

Child's Name (printed) Date

_____ _____

Parent/Guardian Signature Relationship to Patient

PATIENT HEALTH HISTORY AND CONSENT

Patient Information

Patient Name: _____ Date: _____
Last Name, First Name MI (Preferred Name)

Address: _____
Street Apartment # City State Zip Code (County)

Social Security #: _____ Birth Date: _____ Gender: _____ Race: (Opt.) _____

Phone (Home): _____ (Cell): _____

Primary Care Physician: _____
Physician Name Address of Physician Physician Phone Number

Pharmacy: _____
Pharmacy Name City Phone Number

Emergency Contact: _____
Last Name, First Name (Relationship to Patient)

_____
Phone Number for Emergency Contact

Date of Last Dental Visit: _____ Reason for this visit: _____
Where was your last Dental visit? ☐ School Dentist ☐ Mobile Dentist ☐ Other Dentist: _____

Do you have or have you ever had any of the following? Please check all those that apply:

☐ ADHD
☐ AUTISM SPECTRUM DISORDER
☐ AIDS/HIV
CD4 COUNT: _____
☐ ANTICOAGULANT THERAPY
(Coumadin, Heparin, Etc)
☐ ANEMIA
☐ ARTHRITIS
☐ ARTIFICAL JOINTS
What was replaced? _____
When (Year)? _____

BISPHOSPHONATE THERAPY
(Fosamax, Boniva, etc.)
☐ IV ☐ ORAL
How long: _____
☐ CANCER(Type): _____
RADIATION THERAPY ☐ Current ☐ Past
CHEMOTHERAPY ☐ Current ☐ Past

Past Surgeries? Please list with dates
_____
_____
_____
_____
_____

☐ CONGENITAL HEART DEFECTS
☐ DIABETES
☐ DIZZINESS/FAINTING
☐ EPILEPSY
☐ GLAUCOMA
☐ HEAD INJURIES
☐ HEART DISEASE
☐ HEART VALVE REPLACEMENT
☐ HEPATITIS
Type: _____
☐ HIGH BLOOD PRESSURE
☐ KIDNEY DISEASE
☐ LIVER DISEASE
☐ MENTAL/NERVOUS DISORDER
☐ ORAL ULCERS/LESIONS
☐ ARE YOU PREGNANT ☐ Yes ☐ No
Due Date? _____
☐ PACE MAKER
☐ RHEUMATIC FEVER
☐ STOMACH PROBLEMS
☐ STROKE
☐ TUBERCULOSIS

RESPIRATORY PROBLEMS
☐ ASTHMA ☐ COPD

ALLERGIES
☐ CODEINE
☐ PENICILLIN
☐ SULFA
☐ SEASONAL
☐ LATEX SENSITIVITY
☐ OTHER: _____

TOBACCO PRODUCT USE
☐ CIGARETTES
Packs per day? _____
☐ CIGAR, PIPE
☐ CHEW, DIP, BLUNTS
☐ OTHER? _____

DO YOU USE OR HAVE YOU EVER USED ANY OF THE FOLLOWING:
☐ ALCOHOL
☐ COCAINE
☐ MARIJUANA
☐ METHAMPHETAMINE
☐ OPIATES
☐ METHADONE
☐ SUBOXONE

Are you currently taking prescription or over the counter medication(s)? ☐ Yes ☐ No
If yes, please list: _____

Have you ever had any complications following dental treatment or surgery ☐ Yes ☐ No
If yes, please explain: _____

I hereby certify that the preceding answers and information are true and correct to the best of my knowledge.

_____ Date: _____
Signature of patient, parent or guardian

_____ Date: _____
Signature of Dentist, Hygienist

Referral Information

How did you hear about our practice? ☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Radio

Would you like to receive information about other Salvation Army Programs? ☐ Yes ☐ No

Would you like someone from the Salvation Army ministry to call on you? ☐ Yes ☐ No

Parent/Guardian Information AND Insurance Information

Name: _____

Relationship to patient: ☐ Self ☐ Parent ☐ Spouse ☐ Legal Guardian

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____

Street City State ZIP Code

Insurance Plan: _____ Group Number: _____

Claim Mailing Address: _____ City _____ State ____ Zip Code _____

Name of Policyholder: _____ Subscriber ID # _____

Employment Information

The following is for: ☐ Self ☐ Parent/Guardian or other person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street City, State Zip Code Phone

Acknowledgement of Payment for Services and Consent for Treatment

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. This practice will not discriminate against any person receiving dental services because of their inability to pay for services or because payment for the dental services will be made under title XIX ("Medicaid") of the Social Security Act. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

Dental services, including emergency services will be provided at a nominal or reduced charge to persons unable to pay for services upon completion of an application for financial aid and submission of proof of income and family size including but not limited to a tax return (within the past 2 years), unemployment letter, denial letter from Medical Assistance, disability award, social security award, payroll stub, or other as determined by the Salvation Army Dental Center Director. If financial assistance is granted, the patient agrees to adhere to all scheduled appointment times and terms of the financial arrangements. Any breach defined by a "no show" appointment or failure to make payments as scheduled may result in termination of financial assistance.

Patients presenting a valid identification card for dental insurance understand that all dental services will be charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. Checks received by the patient from the insurance carrier should be turned over to this practice for reimbursement of treatments completed. This dental office cannot render services on the assumption that charges will be paid by an insurance company. In the event of non-payment for dental services, the practice reserves the right to suspend of terminate the patient.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of completed services to the Salvation Army Dental Center at the time services are rendered, or within Thirty (30) days of billing if credit shall be extended.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____

Signature of Patient or parent/guardian or other responsible party

_____

Printed Name Relationship to Patient