## Have you been here this current Month?

__ Yes __ No

## Gender:

__ Male

__ Female

__ Transgender

__ Other: _____
*(client gender identity not listed above)*

__ Choose not to answer

## Ethnicity:

*According to federal data collection practices each person should choose an ethnicity and a racial category. "Hispanic/Latino" is defined as people of Latin American descent, regardless of race. For example, a person of African descent from Columbia might choose "African American" as his or her race and "Hispanic/Latino" For his or her ethnicity.*

__ Hispanic/Latino

__ Not Hispanic/Latino

__ Ethnicity Unknown

## Age:

__ 0-4

__ 5-12

__ 13-17

__ 18-25

__ 26-34

__ 35-54

__ 55-64

__ 65 & Older

## Race:

__ African

__ African American or Black

__ Caucasian or White

__ Asian or Pacific Islander

__ Native American

__ Multi-Racial

__ Unknown

__ Other: _____

## Why are you here today?

__ Pain or Swelling

__ Extraction

__ Exam

__ Cleaning

__ Fillings

__ Other: _____

## When was your last dental visit?

__ Within the last year

__ Less than five years ago

__ More than five years ago

__ I've never been to a dentist

## County you live in:

__ Anoka
__ Benton
__ Carver
__ Chisago
__ Dakota
__ Goodhue
__ Hennepin
__ Isanti
__ Kanabec
__ Le Seur
__ Morrison
__ Pierce (WI)
__ Pine
__ Polk (WI)
__ Nicollet
__ Ramsey
__ Rice
__ Scott
__ Sherburne
__ St. Croix (WI)
__ Stearns
__ Washington
__ Wright
__ Other: _____

## How did you hear about us?

__ BEEN HERE BEFORE
__ Boy's and Girl's Club
__ Church
__ CLUES/Mexican Consulate
__ Dental School
__ Dorothy Day Center
__ Food Shelf
__ FRIEND/FAMILY MEMBER
__ Hospital
__ Indian Health Board
__ Internet
__ Medical Teams
__ MN Mission of Mercy
__ Newspaper/Televised News
__ Open Hands Midway
__ People Serving People
__ Phone Book
__ Portico
__ Radio
__ Referring Doctor
__ Saint Paul School
__ Salvation Army
__ School Flyer
__ Senior Linkage Line
__ Sharing and Caring Hands
__ Social Service Agency
__ St. Mary's Clinic
__ Teen Challenge
__ Union Gospel Mission
__ United Way
__ Veteran's Home/Affairs
__ WIC Program
__ Work Force Center
__ Other: _____

# 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 _____

This recognizes that you have received the Notice of Privacy Policy for Hope Dental Clinic. You understand what it contains and have asked any questions you may have.

Name (PRINT):

_____

Signature:

_____

Date: _____

Emergency Contact Information:

Name:_____

Phone:_____

**IF HERE FOR A COMPREHENSIVE EXAM:**

I have read the patient services letter and understand what I am able to receive and the treatment policy at Hope Dental Clinic:

Signature:

_____

Date: _____

# Enrollment Application

**Name (First name and last name):** _____

**Address:** _____

_____

**Home Phone #:** _____ **Cell Phone #:** _____

**Work Phone #:** _____

**E-Mail:** _____

- **Do you have dental insurance or any funds given for dental care?**
  - □ **No**
  - □ **Yes, Please Explain:** _____

    _____

  **Are you eligible for veteran's benefits?**
  - □ **No**
  - □ **Yes, Please Explain:** _____

    _____
- **Number of persons living in your household (this would include: you, dependents and family: that you share an income with (i.e. shared meals, shared bills, etc.).**

  _____ **Persons in the household**
- **Monthly or Yearly combined income of ALL persons living in your household:**
  - **Monthly:** _____
  - **Yearly:** _____

**I understand that the information provided by me is subject to verification by the clinic. I understand that any false information provided by me will result in the denial of any clinic services. I understand misrepresenting medical coverage will immediately terminate my participation and may obligate me to become financially responsible for services given to me through the charity.**

**Applicant Signature:** _____ **Date:** _____

# Failed Appointment Policy

Welcome to Hope Dental Clinic. We are pleased to have you as a patient and will undertake your treatment with us with diligence and care. In order to serve you well, we will need to develop a working relationship with you that requires you to attend all scheduled appointments. Your attendance at the scheduled appointments will reflect your cooperation with our suggested plan of care. As such, we have the following policy in effect regarding your service with us:

## FAILED APPOINTMENTS:

In an effort to provide you with efficient service, please call and notify us at least 24 hours ahead of your scheduled time to confirm or let us know if you need to miss an appointment. We'll be happy to reschedule your appointment as soon as possible to continue your care effectively.

**PLEASE BE AWARE THAT WE DO HAVE A FAILED APPOINTMENTS POLICY FOR SAME DAY CANCELLATION, NON-CONFIRMED AND NO-SHOW APPOINTMENTS:**

**Failed appointments mean:**

**-Non-Confirmed Appointments, which means that you did not notify us at least 24 hours before the appointment time to confirm that you will be present.**

**-Same Day Cancellations, which are appointments cancelled the same day of the appointment.**

**-No-Shows appointments, which mean that you did not come for and YOU did not call in advance to notify the clinic of your intended absence.**

## DISCONTINUATION OF CARE DUE TO MISSED APPOINTMENTS

**If you have two (2) Missed Appointments within any twelve (12) month period, we will need to terminate your treatment with us, as it is difficult to provide competent, effective care under these conditions. Should this occur, we will provide you with a list of other community clinics for continued treatment, if you wish to pursue it. You also have the right to call in the morning to see if there is an opening in the schedule or to request to come in and wait to see if a patient doesn't show up for their appointment. If you come in to wait, there is no guarantee that we will be able to see you and you may wait a few hours.**

**Our ultimate goal is to improve access to appointments to all patients. We hope that by reducing No-Show, Non-Confirmed and Same Day Cancellation Appointments we can provide a greater level of service and access for you and other patients seeking care with us. We thank you for your anticipated cooperation.**

**Your signature below indicates that you understand and agree with the above policies:**

**Patient Name** _____

**Patient signature** _____

**Date** _____