

495 W 4th Street – P O Box 576- Dove Creek, CO 81324
www.dovecreekclinic.org
 Dental – 970-677-3644 Medical – 970-677-2291 Fax – 970-677-2540

2018 PATIENT INTAKE FORM

Legal Name: *First* _____ *Middle* _____ *Last* _____

Preferred Name: _____ **Date of Birth:** _____

Race: (check ONE) White Native American or Alaskan Native Asian Black/African American
 Native Hawaiian Other Pacific Islander Decline to answer

Ethnicity: (check ONE) Not Hispanic/Latino Hispanic/Latino Decline to answer

Preferred Language: _____

Gender Identity: (check ONE)

What sex were you assigned at birth on your original birth certificate?

Male Female Choose not to disclose

What is your current gender identity?

Male Female Transgender Male/F-to-M Transgender Female/M-to-F

Other Choose not to disclose

Sexual Orientation: (check ONE) Straight (not lesbian or gay) Lesbian or Gay Bisexual Something Else
 Don't Know Choose not to disclose

Pronouns Preferred: He/Him She/Her They/Them Other _____

Mailing Address: _____

Home Address: _____

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

Email: _____ **Social Security #:** _____

Employer: _____ **Work Phone:** _____

Are you a U.S. Military Veteran: (check ONE) Yes No

What is the BEST way to contact you: (check ONE) Letter Phone Electronic Portal-medical patients only

Marital Status: (check ONE) Married Domestic Partnership Single

Please Fill Out Below if You Have a: (check ONE) Spouse or Domestic Partner Legal Guardian

Name: _____ **Does this person live with you?** Yes No

Home Address: _____

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

Email: _____ **Social Security #:** _____

Employer: _____ **Work Phone:** _____

What is the BEST way to contact this person: (check ONE) Letter Phone Electronic

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INCOME VERIFICATION

Your Name: _____ Your Household Size _____

Annual Income for Your Household _____

You may qualify for sliding fees or discounted services if your income is 250% or below the federal poverty level.
 (See Federal Poverty Level Table on the next page)

Please inquire about discounted and sliding scale services at the front desk. We offer payment plans as well.
 For more information call 970-677-3658.

!NO ONE WILL BE DENIED SERVICES BASED ON THEIR INABILITY TO PAY!

HOUSING STATUS: NOT HOMELESS HOMELESS (If homeless check applicable box in next row)
 Doubling up Homeless Shelter Street Transitional Unknown

AGRICULTURE STATUS:

1. Have you or a member of your family ever worked in agriculture/farming, as principal employment, at any time in the past 2 years, including but not limited to field crops, orchards, greenhouses, nurseries, aquaculture, bee keeping, tree farms, work with animals such as cattle, dairy, sheep, poultry, fish hatcheries, etc.?
 Yes No (If YES got to question 3, If NO – got to question 2)
2. Have you or a member of your family stopped traveling to work in agriculture because of a disability or age?
 Yes No
3. Have you or a member of your family moved in the past two years to another area (established a temporary home) in order to work primarily in agriculture? Yes No
4. Have you or a member of your family, worked in the past two years primarily in agriculture, on a seasonal basis, without moving away from your home? Yes No

I verify that the above information is accurate to the best of my knowledge.

 Patient or Guardian Signature Date

 Printed Name of Signer if not patient, relationship to patient

Community Health and Dental Clinics receive funds from federal, state and local resources to assist patients. If your income is 250% or below the Federal Poverty Level, you may qualify for reduced costs for services. For more information to see if you are eligible or for an application, ask at the receptionist at the front desk or call 970-677-3658. You may also get an application online at www.dovecreekclinic.org. Affordable payment plans are available as well. Call 970-677-3658 for more information.

Another service offered is Outreach and Enrollment for assistance with purchasing private insurance, as well as obtaining Medicaid and Medicare. We have Certified Application Counselors on staff to assist with enrollment through Connect for Health Colorado and other programs. This is available to patients and non-patients of the clinic. Call 970-677-3657 for more information or to schedule an appointment

FEDERAL POVERTY LEVEL GUIDELINES 2018
This page is for informational purposes only.

Persons in Household	48 Contiguous States and D.C. 2018 Poverty Guidelines (Annual)							
	100%	133%	138%	150%	200%	250%	300%	400%
1	\$12,140	\$16,146	\$16,753	\$18,210	\$24,280	\$30,350	\$36,420	\$48,560
2	\$16,460	\$21,892	\$22,715	\$24,690	\$32,920	\$41,150	\$49,380	\$65,840
3	\$20,780	\$27,637	\$28,676	\$31,170	\$41,560	\$51,950	\$62,340	\$83,120
4	\$25,100	\$33,383	\$34,638	\$37,650	\$50,200	\$62,750	\$75,300	\$100,400
5	\$29,420	\$39,129	\$40,600	\$44,130	\$58,840	\$73,550	\$88,260	\$117,680
6	\$33,740	\$44,874	\$46,561	\$50,610	\$67,480	\$84,350	\$101,220	\$134,960
7	\$38,060	\$50,620	\$52,523	\$57,090	\$76,120	\$95,150	\$114,180	\$152,240
8	\$42,380	\$56,365	\$58,484	\$63,570	\$84,760	\$105,950	\$127,140	\$169,520

Add \$4,320 for each person over 8

If you household income falls within the categories in the table above, you may qualify for sliding fees or discounted services. Please inquire at the front desk for more information or call 970-677-3658.

- **Household:** A household consists of all the persons who occupy a housing unit (house or apartment), whether they are related to each other or not. If a family and an unrelated individual, or two unrelated individuals, are living in the same housing unit, they would constitute two family units, but only one household.
- **Family:** A group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family.
- **Income includes:** earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. Noncash benefits (such as food stamps and housing subsidies) do not count.

Community Health and Dental Clinics receive funds from federal, state and local resources to assist patients. If your income is 250% or below the Federal Poverty Level, you may qualify for reduced costs for services. For more information to see if you are eligible or for an application, ask the receptionist at the front desk or call 970-677-3658. You may also get an application online at www.dovecreekclinic.org. Affordable payment plans are available as well. Call 970-677-3658 for more information.

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Insurance and Payment Information

Patient's Name: _____ **Date of Birth:** _____

Do You Have Medical Insurance or Other Health Coverage?

YES I have Medical Insurance or Other Health Coverage. *Please show your card(s) to the Front Desk now.*

1. What Type of Medical Insurance or Other Health Coverage Do You Have? (Check all that apply)

Private (includes Gov't Employee and Vets) Medicare Medicaid CHP+ CICIP Sliding Scale

2. Do You Have Prescription Drug Coverage (Check ONE): Yes No

3. Please Read: I, the undersigned, certify that I (or my dependent) have Medical Insurance or Other Health Coverage, and assign directly to Community Health Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize Community Health Clinic to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submission.

Signature: _____ **Date:** _____

Printed Name of person signing above: _____

Relationship to patient, if not the patient:

(Check ONE): Mother Father Legal Guardian Legal Representative

4. If You Have Medicare, Please Read and Sign This Medicare Authorization:

I REQUEST THAT PAYMENT OF AUTHORIZED Medicare benefits be made either to me or on my behalf to Community Health Clinic for any services furnished me by the provider of the clinic. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCGS-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, Community Health Clinic agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature: _____ **Date:** _____ **Printed**

Name of person signing above: _____

Relationship to patient, if not the patient:

(Check ONE): Mother Father Legal Guardian Legal Representative

NO I DO NOT have Medical Insurance or Other Health Coverage - If you do not have health insurance, would you like to receive information on other programs? YES NO (Please Read):

I, the undersigned, certify that I (or my dependent) do not have Medical Insurance or Other Health Coverage. I understand that I am financially responsible for all charges. I hereby authorize Community Health Clinic to release all information necessary to secure payment for services.

Signature: _____ **Date:** _____

Printed Name of person signing above: _____

Relationship to patient, if not the patient: (Check ONE): Mother Father Legal Guardian Legal Representative

FINANCIAL RESPONSIBILITY

Who is financially responsible for payment of services rendered for this patient?

Self (Patient) **Other** If you checked **Self** sign at bottom then go to the next page. If you checked **Other**, complete this page.

Name of person financially responsible: _____

Does the patient live with this person: **YES** **NO**

Relationship to Patient: **Father** **Mother** **Legal Guardian** **Other:** _____

If the contact information is NOT the same for this person as the patient please complete contact info for this person.

Mailing Address: _____

Physical Address: _____

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

Email: _____ **Social Security #:** _____

Employer: _____ **Work Phone:** _____

What is the BEST way to contact this person (check one) **Letter** **Phone** **Electronic**

May this person contact the Clinic or be contacted by the clinic for: (Check all that apply or All of the above)

- Emergency May make my appointments May discuss my medical and dental conditions
- May pick up my medication May pick up my medical and dental records May handle billing processes
- ALL of the above**

Is another person also financially responsible? Please complete the following for that person.

Name of person financially responsible: _____

Does the patient live with this person: **YES** **NO**

Relationship to Patient: **Father** **Mother** **Legal Guardian** **Other:** _____

If the contact information is NOT the same for this person as the patient please complete contact info for this person.

Mailing Address: _____

Physical Address: _____

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

Email: _____ **Social Security #:** _____

Employer: _____ **Work Phone:** _____

What is the BEST way to contact this person (check one) **Letter** **Phone** **Electronic**

May this person contact the Clinic or be contacted by the clinic for: (Check all that apply or All of the above)

- Emergency May make my appointments May discuss my medical and dental conditions
- May pick up my medication May pick up my medical and dental records May handle billing processes
- ALL of the above**

I certify that the above is true and correct to the best of my knowledge

Signature: _____ **Date:** _____

Printed Name of person signing above: _____

Relationship to patient, if not the patient: (Check ONE): **Mother** **Father** **Legal Guardian** **Legal Representative**

Understanding How the Clinic Handles Your Account

Please Read and Initial each item to show your understanding:

Discounts & Ways to Pay

- I understand that I will receive a 10% discount for paying cash at the time of service.
- I understand I cannot be refused care due to my inability to pay and that I will be asked for verification of my inability to pay.
- I understand that I may be offered a short-term payment plan for my account.
- I understand that I may be eligible for reduced cost of services received and that I must contact the Clinic Eligibility Technician to learn what I must do to qualify for these reduced costs.

What Happens When I Do Not Pay?

- I understand that I will receive up to 3 statements and should my account remain unpaid, a certified mailing of the statement will be mailed to me.
- I understand that should my account remain unpaid within 15 days of the certified mailing; my account will be turned over for collections with an outside agency.
- I understand that if my statement is returned to the clinic as undeliverable, my account will go immediately to collections with the outside agency.
- I understand that I will be responsible for all costs including Attorney fees and court costs should my account be sent to the outside collection agency.
- I understand there will be a charge of \$25 for all returned item checks. Additional charges will be applied as allowed by CRS 13-21-109.

Refunds

- I understand that if the Clinic issues me a refund check then I must cash this refund check within six months of issuance or else, after the Clinic as attempted to contact me via all methods of contact authorized by me for the Clinic, the refund check shall be considered a donation to the Clinic.
- I understand that if the Clinic issues me a refund check that is returned to the Clinic as “undeliverable” then, after the Clinic as attempted to contact me via all methods of contact authorized by me for the Clinic, the refund check shall be considered a donation to the Clinic.

Signature: _____ **Date:** _____

Printed Name of person signing above: _____

Relationship to patient, if not the patient:

(Check ONE): Mother Father Legal Guardian Legal Representative

Clinic Contact Permissions

Patient's Name: _____ **Date of Birth:** _____

Who in your family or friends may contact the clinic or be contacted by the clinic

If you leave this blank, we cannot contact your family or friends in case of emergency.

If you leave this blank, we cannot accept calls from your family and friends for the following services:

Name: _____ Phone: _____ Relationship: _____

- Emergency May make my appointments May discuss my medical and dental conditions
- May pick up my medication May pick up my medical and dental records May handle billing processes
- ALL of the above**

Name: _____ Phone: _____ Relationship: _____

- Emergency May make my appointments May discuss my medical and dental conditions
- May pick up my medication May pick up my medical and dental records May handle billing processes
- ALL of the above**

Name: _____ Phone: _____ Relationship: _____

- Emergency May make my appointments May discuss my medical and dental conditions
- May pick up my medication May pick up my medical and dental records May handle billing processes
- ALL of the above**

Name: _____ Phone: _____ Relationship: _____

- Emergency May make my appointments May discuss my medical and dental conditions
- May pick up my medication May pick up my medical and dental records May handle billing processes
- ALL of the above**

Do you have a caregiver?

If someone helps you in your home with taking medications, daily care, making decisions, or someone has POA over you, please fill out the following:

Who gives you daily medications or other medical care?

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Who helps you with daily bathing, dressing, feeding, toothbrushing etc?

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Who helps you make medical and dental decisions?

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Who has Power-of-Attorney (POA) over you? Please bring us legal PROOF OF POA

Name: _____ Phone: _____ Relationship: _____

PLEASE bring us Proof of Guardianship or Legal Custodianship for all Legal Guardians/Custodians listed above.

Signature: _____ **Date:** _____

am: the Patient Patient's Spouse or Domestic Partner Patient's Mother, Father, or Legal Guardian.

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Privacy Notice – Disclosure Permissions – Personal Contact Permission

Patient's Name: _____ **Date of Birth:** _____

1. Privacy Notice: Acknowledgement of Receipt of Notice of Privacy Practices and No Show Policy

(Check ONE) I **Have** or **Have NOT received:**

A copy of the Notice of Privacy Practice for Community Health Clinic and Community Dental Clinic, and a copy of the No Show Policy. I acknowledge that Community Health Clinic and Community Dental Clinic reserve the right to modify both the Privacy Practices outlined in the Notice of Privacy Practice, and the No Show Policy.

2. Disclosure Permissions: Patient Consent for Use and Disclosure of Protected Health Information

(Check ONE) I **DO** or **Do NOT** authorize:

Any previous or current health care providers and organizations to request, disclose, or use Protected Health Information with Community Health Clinic and Community Dental Clinic for the purposes of Medical and Dental treatment, billing, and insurance.

This may or may not include information pertaining to mental health, sexually transmitted diseases, and/or substance and/or alcohol abuse.

3. Personal Contact Permissions: How the Clinic May Contact Me

I understand that Community Health Clinic and Community Dental Clinic may need to contact me from time to time about my treatment, payment, and other health care such as **appointment reminders, lab results**, insurance items, among other things.

Community Health Clinic and Community Dental Clinic may contact me in the following ways:

By Phone: (Check ONE for each category)

- Home** Detailed message Leave only a message to call the Clinic phone # No message
- Cell** Detailed message Leave only a message to call the Clinic phone # No message
- Work** Detailed message Leave only a message to call the Clinic phone # No message
- Text** Detailed message Leave only a message to call the Clinic phone # No message

Letter to me at my mailing address.

Electronic Communication via Clinic Web Portal

Signature: _____ **Date:** _____ **If**

patient is a minor, I am this child's (Check ONE): **Mother** **Father** **Legal Guardian**

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Authorization for Use and Disclosure of Health Information

Patient's Full Name: _____ Date of Birth: _____

Best Contact Phone Number: _____

Please tell us about other health care providers you have seen so that we can request your medical records if necessary and better understand your health history.

Choose one below	Your regular Health (Primary) Care Provider?	What to Fill Out
<input type="checkbox"/> New Patient or not seen here in the last 2 years <div style="text-align: right; margin-right: 20px;">→</div>	<input type="checkbox"/> Community Health or Dental Clinic	Fill out ALL 1-4 below
	<input type="checkbox"/> Someone Else	Fill out 1 only
<input type="checkbox"/> Seen at this clinic within the last 2 years <div style="text-align: right; margin-right: 20px;">→</div>	<input type="checkbox"/> Community Health or Dental Clinic	Fill out 2-4 below
	<input type="checkbox"/> Someone Else	Fill out 1 only

1. Who is/was your previous regular Health (Primary) Care Provider? (Doctor, Physician Assistant or Nurse Practitioner)

Doctor or Clinic Name:	Address/City/Phone	Patient Signature

2. Do you see any Specialists? Yes No

Current Specialists Doctor or Clinic Name:	City/State/Phone	Patient Signature

3. Have you seen any Specialists in the last year that you no longer see? Yes No

Previous Specialists Doctor or Clinic Name:	City/State/Phone	Patient Signature

4. IF YOU ARE A FEMALE, have you ever received Well Woman (PAP Smear) care or seen an OB/GYN? Yes No

Most Recent Well Woman Doctor or Clinic Name:	City/State/Phone	Patient Signature

Authorization for Use and Disclosure of Health Information

Patient's Full Name: _____ Date of Birth: _____

I understand there are Colorado and Federal guidelines about my right to confidentiality and protection of my individually identifiable health information (CFR 42 Part 2, CRS 25.1, HIPAA). Except in situations legally required or permitted, information about me cannot be released to persons or agencies outside the treatment team without my written permission. I hereby authorize Community Health Clinic, Community Dental Clinic, and its providers to send, receive, use or disclose health information about me to the providers I listed on the first page of this Authorization for Use and Disclosure of Health Information form.

(Please check one)
 I wish to **INCLUDE** **EXCLUDE** any records concerning substance abuse disorder.

Other Important Information:

1. My treatment by Community Health Clinic and Community Dental Clinic does not depend on signing this authorization unless treatment is required by a court or other authorized third party.
2. This authorization will expire in one year. I may revoke my authorization in writing at anytime.
3. **I understand and accept that these records may contain documentation of HIV, STD, and drug and/or alcohol information.**
4. Copies of this form may be used in lieu of the original. Signatures received by fax will be accepted.
5. Community Health Clinic and Community Dental Clinic cannot guarantee that recipients of information disclosed through this authorization will not be re-disclosed to another party. The recipient may or may not be subject to federal laws protecting health information.

Patient Signature	Date	Witness Signature
Representative Signature	Date	If Representative, relationship to patient

REVOCACTION: I revoke my authorization for this use and disclosure of my health information.

Patient/Representative Signature	Date	Witness Signature
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MEDICAL HISTORY

Patient's Name: _____ **Date of Birth:** _____

Certain medical problems or medications may affect your dental health or dentistry we provided. Please answer the following questions.

	If "Yes", briefly explain. If more room is needed use the next page.	
Are you under a physician's care now?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever been hospitalized or had a major operation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever had a serious head or neck injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you taking any medications, pills or drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, PLEASE FILL OUT THE NEXT PAGE
Do you take, or have you taken, Phen-Fen or Redux?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you use alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you use tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you allergic to any of the following? (Check all that apply)		
<input type="checkbox"/> Aspirin <input type="checkbox"/> Penicillin <input type="checkbox"/> Codeine <input type="checkbox"/> Acrylic <input type="checkbox"/> Metal <input type="checkbox"/> Latex <input type="checkbox"/> Sulfa Drugs <input type="checkbox"/> Local Anesthetics <input type="checkbox"/> Other, please explain: _____		
Do you use controlled substances? <input type="checkbox"/> Yes <input type="checkbox"/> No. If yes, please explain: _____		
Women Only – Are you... <input type="checkbox"/> Pregnant/Trying to get pregnant? <input type="checkbox"/> Nursing? <input type="checkbox"/> Taking oral contraceptives?		

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

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

Other Serious Disease not listed (please explain): _____

To the best of my knowledge, I accurately answered the questions on this form. I understand that providing incorrect information about the patient can be dangerous to the patient's health. I will inform the dental office of any changes in medical status.

Signature: _____ **Date:** _____

If the patient is a minor, I am the child's (CHECK ONE) Mother Father Legal Guardian

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MEDICATIONS & OTHER INFORMATION

Please list all medications or drugs (prescription, over the counter, etc.) and supplements (vitamins, minerals, herbs, etc).
 You can also use this page to provide additional information from the previous page.

Name	Dosage	How often do you take this?	Why do you take this?
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Dental – 970-677-3644 Medical – 970-677-2291 Fax – 970-677-2540

CONSENT TO PROCEED

I authorize Community Health Clinic Dentist and designated Staff to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (Including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that dental radiographs (X-Rays) will be used to aid in diagnosis and treatment of oral disease. I understand that clinic staff will take precautions to minimize unnecessary exposure to radiation. I understand that all radiation has some potential health risk.

I understand that it is not always possible to detect all existing oral disease that may be present and that some problems may not be prevented, such as tooth fracture. It is often impossible to adequately assess the condition of the tooth under old crowns or fillings without removing them.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Occasionally a tooth that is worked on will subsequently develop pulp necrosis (dead tooth) requiring Root Canal treatment, referral or even extraction. Dental materials and medications may trigger allergic or sensitivity reactions

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require series of x-rays to be taken by a physician or hospital and may in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription and non-prescription drugs that are currently being taken or that have been taken in the past. I also understand that a complete and accurate health history is required to provide appropriate treatment. I recognize that failure to inform the dentist and staff of medications and health conditions could result in life threatening complications including but not limited to: drug interactions, infection, heart failure, stroke, allergic anaphylaxis, bleeding and death.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Signature: _____ **Date:** _____

If patient is a minor, I am this child's (Check ONE): Mother Father Legal Guardian

Witness: _____ **Date:** _____