School Based Dental Program

PATIENT INFORMATION

Name (last, first, middle):	Date of Birth: ___/___/___ Age:
Address:	☐ Female ☐ Male
City: **State:** **Zip:**	Social Security #:
Phone – home: cell: other:	
Relationship Status: ☐ Single ☐ Spouse / Partner ☐ Widowed	
Ethnicity: ☐ Anglo ☐ African American ☐ Hispanic ☐ Native American – Tribe:	
☐ Asian ☐ Pacific Islander ☐ Native Hawaiian ☐ More than one Race ☐ Do not wish to report	
Military Status: ☐ not applicable ☐ Active ☐ Retired	
Emergency Contact – Name:	Relationship:
Address:	Phone:

PRIMARY INSURANCE / PAYMENT INFORMATION

Person Responsible for Account – Name:		Date of Birth: ___/___/___
Relationship to Patient:	Social Security #:	Employer:
Phone – home:	cell:	work:
Total number immediate family members – Adults:	Children:	
Total Household Income:	☐ *weekly* ☐ *bi-weekly* ☐ *month* ☐ *year*	
Insurance – *Plan Name:*		*Group Number:*
Subscriber – *Name:*		*Subscriber Number:*

I understand that all professional services are charged to the patient and the patient is responsible for payment regardless of insurance coverage. It is customary to pay for services when rendered on the date of service.

AUTHORIZATION TO RELEASE INFORMATION TO INSURANCE

Patient Initials: I authorize First Nations Community HealthSource to release any medical or other information that may be necessary for the completion of insurance claims, review of services or receipt of benefits to third party payers, the third party payer's agent and/or representative.

Patient signature: _____ Date: ___/___/___

Patient representative signature: _____ Date: ___/___/___

Relationship to patient: _____

If patient is unable to sign state reason: MINOR

☐ Interpreter used – printed name: _____

Witness: _____ Date: ___/___/___

FIRST NATIONS COMMUNITY HEALTHSOURCE

PATIENT INFORMATION

Patient Name: _____

Date of Birth: ___/___/___

Medical Record Number: _____

9/26/08

Write "NONE" if any of the following do not apply

FIRST NATIONS COMMUNITY HEALTHSOURCE

HEALTH HISTORY - ADULT

Please complete this form to help us give you the best possible care

Check conditions below that YOU have now or have had in the past.

- ☐ Alcoholism/drug addiction
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Blood clot in leg or lung
- ☐ Cancer _____
- ☐ Depression
- ☐ Diabetes – type: _____
- ☐ Epilepsy /Seizures
- ☐ Genital discharge / pain
- ☐ Heart Disease / Attack
- ☐ Hepatitis – type: _____
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Kidney disease
- ☐ Lung disease
- ☐ Mental health problems
- ☐ Migraines
- ☐ Rheumatic fever
- ☐ Sexually transmitted infection
- ☐ Stomach problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Thyroid _____
- ☐ Ulcer
- ☐ Urinary problems / pain

Hospitalization, surgery, serious injuries	year

FAMILY HISTORY

Check if any family members have had any of the following. *Write relationship to you in the space.*

- ☐ Alcoholism, drug addiction
- ☐ Cancer – type:
- ☐ Depression
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Lung disease (emphysema/TB)
- ☐ Stroke

SOCIAL HISTORY

Relationship status: ☐ Single ☐ Spouse/partner ☐ Widowed **Number in Household**: _____adults _____children

Education (last grade/degree completed): _____ **Your occupation:** _____

Do you have financial concerns? ☐ No ☐ *Yes* _____

Do you exercise? ☐ No ☐ Yes – Activity: _____ How often? _____

Allergies:

Current Medications: *Include prescription, vitamins and over the counter / herbal preparations.*

NUTRITION

Special diet: _____

Significant weight change in the past 6 months?
☐ No ☐ Yes - _____ lbs. ☐ gain ☐ loss

Do you get enough to eat? ☐ Yes ☐ *No*

Do you have problems with chewing or swallowing?
☐ No ☐ *Yes - describe:* _____

WOMEN's Health:

Are you pregnant? _____

Are you nursing? _____

Trying to become pregnant? _____

Are you taking birth control? _____

MEN's Health: Last prostate exam: _____

Do you perform ***Self Testicular Exams?*** ☐ Yes ☐ No

Last exam	Provider	month/year
Medical		
Dental		
Eye		
Hearing		
Colon Screening		

Completed by: _____ ☐ Patient Other: _____

Nurse Review: _____ **Provider review:** _____

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COMMUNITY HEALTHSOURCE

Please select which of the following best describes your housing situation:

___ Rent/Lease Apartment/House

___ Own House

___ Living with Roommate/Family/Others (and do not pay rent)

___ Living in a Transitional Housing or Public Housing program

___ Living in a Shelter

___ Living on the Streets

___ Just released from an Inpatient Facility

___ Just released from a Correctional Facility

___ Living at a hotel/motel

___ Other (identify: _____)

FIRST NATIONS COMMUNITY HEALTHSOURCE

Parental Consent Form for Dental Treatment

Minor/Child Consent

I, being the parent or guardian of _____, do hereby request and authorize the denal staff to perform necessary dental services for my child, including x-rays, administration of anesthesia, restorations, oral surgery, hygiene and any services deemed advisable by the doctor, even if I am not present in the operatory during the dental treatment. _____ Initial

Permission to Treat

Because your child is a minor it is necessary to have signed permission from a parent of guardian. The signature affixed below authorizes examination and treatment as necessary and the use of procedures the doctor/hygienist may deem necessary during the performance if their services. Furthermore the undersigned accepts responsibility of any financial obligations incurred for treatment of this patient. _____ Initial

Dental Treatment

I understand that during the treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. I give permission to the dentist/hygienist to make any/all changes and additions as necessary. I understand that I am responsible for all charges incurred, regardless of my insurance status. _____Initial

Consent fur use and disclosure of health information HIPPA PRIVACY POLICY

You have the right to read our Notice of Privacy Practices before you decide whether to sign the consent. I understand that by signing this consent form, I am giving my consent to the use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations. _____Initial

Acknowledgement of receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of our Notices of Privacy Practices. _____Initial

Parent Signature:_____

Relationship to child:_____

Date:_____

FIRST NATIONS
COMMUNITY HEALTHSOURCE

5608 Zuni Rd. SE
Albuquerque, NM 87105
(505) 262-6547

Notice of Privacy Practices

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of

your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Minimum Necessary: We may use or disclose only the minimum necessary private health information to accomplish the intended purpose.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: *You* have the right to look at or get copies of your health information with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You may request access by sending us a letter to the address at the end of this Notice. We will charge you reasonable cost-based fee for expenses such as copies and staff time. If you request copies, we will charge you $0.75 for each page, $10 for staff time to locate and copy your health information, the actual cost of reproducing the x-rays, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use of disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or location, and provide satisfactory explanation how payment will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices, or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint with the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Lanaeda Ortiz, Human Resources
Manager Address: 5608 Zuni SE Albuquerque, NM 87108
Telephone: (505)262-6560
Fax: (505)262-0781
E-mail: Lanaeda.ortiz@ihs.gov