Patient Name_____Date of Birth_____

HELP Dental Clinic

12420 Warwick Blvd, Suite 1A, Newport News, VA 23606 (757)586-5107 Office (757)723-0649 Fax

PRIMARY REGISTRATION FORM

1. Patient Information			
First Name		**Social Security Number**	
Middle Name		**Date of Birth:**	
Last Name		**Email Address:**	
Home Telephone		**Mobile Telephone**	
Street		**City, Zip Code**	
Race:		**Gender**	☐ Male ☐ Female ☐ Other
Language Spoken	English ☐ Other_____	**Employment Status**	☐FT ☐PT ☐Self ☐Unemployed ☐Retired ☐Disabled
Veteran Status	No ☐ Yes ☐	**Household Size**	_____Children _____Adults
Living Arrangement	☐ Mortgage ☐Rental ☐HUD/Section 8 ☐Living w/ Family ☐Homeless	**Covered by Insurance**	☐ No ☐ Yes

How Did You Hear About Us? ☐ Google Search ☐ Facebook/ Instagram Ad ☐ Postcard/ Flyer ☐ Sign ☐ Friend or Relative ☐ Referred By: ☐ Other:

2. Patient ID & Documents Confirmation	
Please provide the following documents / information for proof of residency: ☐ Photo ID (example: Passport / Driving Licence) ☐ Proof of home address not more than 3 months old (ex: Utility Bill / Bank Statement) **And at least one of the following for proof of household income:** ☐ Tax Return (most recent) -Pages 1 & 2, Schedule C ☐ Wages (last 4 Pay stubs) – SSI Letter – Social Security Letter – Pension Letter ☐ Child Support or Alimony ☐ VEC DG91 or Unemployment Award Letter ☐ Household Support Letter Notarized **If you have Medicare, please provide:** ☐ Medicare Card (if applicable)	Applications submitted without the required documents cannot be processed. Visits will not be scheduled without all necessary paperwork for approval.

3. Patient Attestation	
The above information is true to the best of my knowledge. I understand that the clinic staff may need to verify certain information to confirm eligibility. I understand withholding information or giving false information will make me ineligible for care at the clinic. I also understand that service eligibility for the clinic's services I agree to notify the clinic should my household income change, or I become insured. **I attest that I do not have health and dental insurance.** **(Medicare Recipients receiving Part A and/or B may qualify for dental care; Disabled Veterans under 100% rating may qualify for dental care; Medicaid recipients do not qualify for care)**	
Patient Signature of Understanding	X_____ Date _____

4. About Our Clinic

HELP's mission is to provide dignifying, empowering, and faith-based safety-net shelter, healthcare, and support to our community's most vulnerable people.
Services are provided to individuals that are 139% to 300% of the Federal Poverty Level and have no Insurance Coverage.

Clinic Hours:
Mon-Thurs 8:30AM - 4:30PM
Office: 757-586-5107
Fax: 757-723-0649

Dental Care is provided by appointment only. Please call the office to schedule your appointment. We cannot accommodate walk-ins.

The HELP Clinic incurs expenses whether or not you show up to your visit. You must call at least 48 hours prior to your scheduled visit to cancel or you will be charged a $25 fee.

5. Consent to Services

Your signature on this form shows that you understand that the HELP Medical Dental Clinic service providers are working with you as unpaid/paid staff. Because of this, state and federal law offers them protection from lawsuits for acting in good faith.

I consent to such medical/dental treatment and examinations, including diagnostic and lab procedures, dental procedures including extractions that are necessary treatment in the opinion of my provider (e.g., physician, nurse practitioner, dentist)
Immunity from civil liability for any act or omission resulting in death or injury to a patient if: The volunteer was acting in good faith and in the course and scope of the volunteer's duties or functions within the organization. The services provided are within the scope of the license of the volunteer or employee.
I understand that should a HELP employee or volunteer be exposed to my blood/body fluid in a way that might allow transmission of infection due to blood borne diseases (HIV, Hep A,B,C) or other communicable diseases, according to Virginia State Law, for the safety, health and possible treatment of the health care provider/staff member, samples of my blood or bodily fluid may be tested for infection at NO COST to me. I also understand that health care providers are obligated to submit to blood tests for certain infectious diseases if I am inadvertently exposed to their blood or body fluid during my treatment.

Extraction of teeth is an irreversible process and, whether routine or difficult, is a surgical procedure. As in any surgery, there are some risks. They include, but are not limited to, the following:
1. Swelling and/or bruising and discomfort in the surgery area.
2. Stretching of the corners of the mouth resulting in cracking or bruising.
3. Possible infection requiring additional treatment.
4. Dry Socket- Jaw pain beginning a few days after surgery usually requiring additional care. It is more common from lower extractions, especially wisdom teeth.
5. Possible damage to adjacent teeth, especially those with large fillings or crowns (caps).
6. Numbness, pain, or altered sensations in the teeth, gums, lip, tongue (including possible loss of taste sensation) and chin, due to the closeness of tooth roots (especially wisdom teeth) to the nerves which can be bruised or damaged. Almost always sensation returns to normal, but in rare cases, the loss may be permanent.
7. Trismus- Limited jaw opening due to inflammation or swelling, most common after wisdom tooth removal. Sometimes it is a result of Jaw Joint Disorder (TMJ), especially when TMJ disease already exists.
8. Bleeding- Significant bleeding is not common, but persistent oozing can be expected for several hours.
9. Sharp ridges or bone splinters may form later at the edge of the socket. These usually require another surgery to smooth or remove.
10. Incomplete removal of tooth fragments. To avoid injury to vital structures such as nerves or sinus, sometimes small root tips may be left in place.
11. Sinus Involvement. The roots of the upper back teeth are often close to the sinus and sometimes a piece of root can be displaced into the sinus or an opening may occur into the mouth that may require additional care.
12. Jaw Fracture- While quite rare, it is possible in difficult or deeply impacted teeth.

X_____**Patient Signature**

6. Authorization for Family Access to Dental Records and Information

I want to exercise my right to limit access to my medical/dental records or discussion regarding my medical/dental condition. No other person that the individuals listed below have permission to have access to my medical/dental records or to speak with a HELP provider/staff member.

*Name*_____ *Relationship*_____*Phone Number*_____

X_____**Patient Signature**

7: Patient Declaration and Personal Data Statement

Your personal information:

The information collected on this application form will be used by Richard F Clark HELP Medical & Dental Clinic (hereafter the 'Practice') for the purposes of healthcare related services and practice administration in accordance with HIPPA.

Personal data relating to you will be retained by the Practice for the purposes of providing you with medical/dental and healthcare related services both in the Practice and where appropriate at the premises of other healthcare providers. This may require your personal data including relevant details of your medical history to be shared with other healthcare providers for the purpose of referrals and for other lawful purposes related to the Practice procedures.

HELP Dental Clinic takes confidentiality and the protection of your personal data very seriously and we will never share your information with any third parties, companies or otherwise without your explicit consent prior to doing this.

You have the right to:

- Have your health record sent directly to another provider
- Have your health record sent directly to Social Security Disability by request
- Ask us to limit the information we share
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information

We may use and share your information as we:

- Help manage the health care treatment you receive
- Report statistical information on behalf of our organization
- Help with public health and safety issues
- We will share information about you if state or federal laws require the information be shared
- We can share health information with a coroner, medical examiner, or funeral director when an individual die.
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety
- I understand that the Practice has the right to accept or decline my registration application at any time.

X_____**Patient Signature**

8. Patient Responsibilities and Referrals

I agree to abide by the following responsibilities and conditions:
PATIENT RESPONSIBILITY
Clinic:

- I will update any changes in household income, address, phone number, or other personal information in a timely manner.
- I understand my responsibility to remain in good standing by applying every 12 months with current documents. If my coverage lapses, I understand that medications and treatment will not take place until I re-enroll.
- Be respectful to staff/providers/specialists/volunteers. HELP will not tolerate disrespectful or rude behaviour toward any staff or volunteer, including specialists and their staff to which patients may be referred.
- Appointments must be cancelled 48 hours prior to the scheduled appointment. Not enough notice or no shows will result in a **$25.00 fine**.
- If I am suspected to be under the influence of alcohol or drugs, I will be asked to reschedule my appointment.

X_____**Patient Signature**

9. Medical/Dental Record Release Form

I hereby authorize and request _____ to release all medical records, notes, diagnosis codes, medications, laboratory/imaging reports and Specialty care concerning myself to:

HELP Dental Clinic – 12420 Warwick Blvd, Suite 1A, Newport News, VA 23606 (757)586-5107 Office **(757)723-0649 Fax**

Dates of Service : PAST 2 YEARS

*Name*_____ *DOB* _____

Last Four Digits of Patient SSN _____

X_____**Patient Signature**

10. Cost of Services

The HELP Clinic is a non-profit organization that is funded through a combination of grants, donations, and other contributions to ensure that services are available for our community. In order to help fund this care, HELP asks for your help as a patient. **HELP asks that all patients provide a $25 donation toward the cost of their care for each visit to the clinic.** Patients who cannot afford to donate towards their visit will not be denied service or turned away. _____(initial)

Dentures, Night Guards, Crowns, Bridges, and other products are not included in the $25 donation. All dental products will be provided on a sliding fee scale based on household income. _____(initial)

Patient Signature of Understanding	X_____ Date _____

********** *For Practice Use Only* **********

Total Household Income	**$**	**Reviewed & Entered**	
% FPL		**Medical Card Issued on**	
Coverage Dates	to	**Athena ID**	
Medicaid Check			

HELP Dental Clinic

www.helpdental.org
12420 Warwick Blvd, Suite 1A, Newport News, VA 23606
dentalclinic@helphampton.org
(757)586-5107

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____* _____* _____ _____
Last First MI Preferred Name

Title: _____ **Gender:*** ◯ Male ◯ Female **Family Status:*** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date:* _____ **Prev. Visit:** _____ **Email Address:**

_____

Phone: _____* _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

Address: _____* _____
Address 1 Address 2

_____* _____* ____-____*
City State Zip Code

Are you in good health? ◯ Yes ◯ No

Have there been any changes in your health in the last year? ◯ Yes ◯ No

If Yes, please explain:

_____

_____

Date of your last physical exam: _____

Do you currently have a physician? ◯ Yes ◯ No

If Yes, please provide their name, address, and phone number(s):

_____

_____

Have you ever been hospitalized for any surgical or serious illnesses? ◯ Yes ◯ No

If Yes, please explain:

_____

_____

Are you taking any prescription or non-prescription medicine? ◯ Yes ◯ No

If Yes, what medications are you taking?

_____

_____

Do you use tobacco products? ◯ Yes ◯ No

Do you or have you used controlled substances? ◯ Yes ◯ No

WOMEN ONLY:

Are you pregnant, think you may be pregnant, or nursing? ◯ Yes ◯ No

Are you taking birth control? ◯ Yes ◯ No

Are you allergic to or have you had reactions to any of the following:

- ☐ Local anesthetics (novocaine)
- ☐ Penicillin or other antibiotics
- ☐ Sulfa drugs
- ☐ Barbiturates or sedatives
- ☐ Aspirin
- ☐ Iodine
- ☐ Any metals(nickel, mercury)
- ☐ Latex or rubber
- ☐ Other: _____

Do you or have you ever had any of the following conditions:

- ☐ Abnormal bleeding
- ☐ Bruise easily
- ☐ Blood transfusion
- ☐ Blood thinner
- ☐ REDUX/FEN-PHEN use
- ☐ FOSAMAX/BONIVA/ACTONEL or other cancer med use
- ☐ Contact lenses
- ☐ Rheumatic heart disease
- ☐ Rheumatic scarlett fever
- ☐ Heart defect
- ☐ Heart murmur
- ☐ Heart trouble
- ☐ Heart attack
- ☐ Angina
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Pacemaker
- ☐ Heart surgery
- ☐ High/low blood pressure
- ☐ Congentital heart problem
- ☐ Swelling of feet, ankles, or hands
- ☐ Heapatitis, jaundice, or liver disease
- ☐ Stroke
- ☐ Sinus trouble
- ☐ Lung or breathing problems
- ☐ Asthma or hay fever
- ☐ Hives or skin rash
- ☐ Fainting or dizzy spells
- ☐ Diabetes
- ☐ AIDS or HIV infection
- ☐ Thyroid problems
- ☐ Allergies
- ☐ Arthritis or rheumatism
- ☐ Artificial joints or pins
- ☐ Stomach ulcer
- ☐ Kidney trouble
- ☐ Tuberculosis
- ☐ Persistant cough
- ☐ Cough that produces blood
- ☐ Chemotherapy (Cancer, Leukemia)
- ☐ Sexually transmitted disease
- ☐ Epilepsy or seizures
- ☐ Anemia
- ☐ Glaucoma
- ☐ Nervousness
- ☐ Tonsillitis
- ☐ Tumors
- ☐ Mental health care
- ☐ Back problems
- ☐ Chemical dependency
- ☐ Mitral valve prolapse
- ☐ Cortisone treatment
- ☐ Cold sores or fever blisters
- ☐ Hypoglcemia
- ☐ Eating disorders
- ☐ Other: _____

BY SIGNING BELOW, I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BY DANGEROUS TO MY HEALTH.

Patient Signature:

Signature _____ **Date** _____

Provider Signature:

Signature _____ **Date** _____

Patient Name: _____ * _____ * ____ _____
Last First MI Preferred Name

Reason for today's visit:

_____

_____

When was your last dental visit?

What was done at your last dental visit?

_____

_____

Previous dentist (name and location):

_____

_____

When and where was your last complete series of dental x-rays?

_____

_____

How often do you brush your teeth? _____

How often do you floss your teeth? _____

Do any of the following conditions apply to you?

- ☐ Gums bleed while brushing or flossing
- ☐ Teeth sensitive to sweet or sour
- ☐ Sores or lumps in or near mouth
- ☐ Clicking, popping, difficulty opening or closing
- ☐ Frequent headaches
- ☐ Cheek or lip biting
- ☐ Food gets caught between teeth
- ☐ Bite plate or other appliance wearing
- ☐ Prolonged bleeding after extractions
- ☐ Teeth sensitive to hot or cold
- ☐ Pain in any teeth
- ☐ Head, neck, or jaw injuries
- ☐ Difficulty chewing
- ☐ Clenching or grinding your teeth
- ☐ Loose teeth
- ☐ History of periodontal (gum) disease
- ☐ Difficult extractions in the past
- ☐ Dentures or partials, if yes, how old? _____

If you could change anything about your smile, what would it be?

_____

_____

Response Date: _____