701 17th Avenue West
Bradenton, Florida 34205
PHONE: (941) 567-6156
FAX: (941) 761-5383

Turning Points Medical and Dental Clinic

New Patients Are Always Welcome!

How did you hear about us?

- ☐ Internet/Social Media
- ☐ Referral from Family or Friend: _____
- ☐ Employer: _____
- ☐ Health Fair/Event: _____
- ☐ Church: _____
- ☐ Agency: _____
- ☐ Medical Center/Provider: _____
- ☐ Bus Ad: _____
- ☐ Radio: _____
- ☐ Other: _____

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Turning Points Medical and Dental Clinic
Patient Eligibility Information

To be seen in the medical or dental clinic you must meet all of the following criteria:

- Be a Manatee County resident age 18-64
- Have **no insurance**. No Medicaid, No Medicare, or No private insurance
- Meet income guidelines and show proof of low or no income
- Complete all new patient paperwork

Please bring this information in with you eligibility packet prior to your first appointment:

- Valid photo ID- Driver's License, Id, Passport
- Proof of address- Official Mail, lease, etc., but no junk mail
- Proof of income- Last 3 months' paystubs, bank statement, Social Security, or a letter of support
- Proof of food stamps- Show proof of amount and eligibility. Must be current.
- Proof of Medicaid Denial**-** Required if you would like to receive medical services. You may print out the letter once denied at https://www.myflorida.com/accessflorida/
- Medication- Bring all medications to your first office visit

Dental Emergency Walk Ins

Clinic opens at 8:00 am, walk-ins taken on a first come, first served basis. Restricted to those with severe pain or swelling. Limited to dentists' availability.

HIPAA NOTICE OF PRIVACY PRACTICES

Health Insurance Portability and Accountability Act

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment or health care operations (TPO) for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. 'Protected health information' is information about you, including demographic information that may identify you that relates to your past, present, or future physical or mental health or condition and related health care services.

Use and Disclosures of Protected Health Information Uses and Disclosures of Protected Health Information. Your protected health information may be used and disclosed by your physician, our office, providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health, your health care, and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information as necessary, to a health agency that provides care to you or your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Healthcare Operation: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may disclose your protected health information as necessary, to contact you of your appointment. We may use or disclose your protected health information in the following situation without your authorization. These situations include: as required by law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect, Food and Drug Administration requirements; Legal Proceedings; Law Enforcement Coroners, Funeral Directors, and Organ Donation; Required Users and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your rights: You have the right to inspect and copy your protected information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information complied in reasonable

anticipation of use in a criminal, civil, or administrative action or proceeding and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as describes in the Notice of Privacy Practices. Your request must state the specific restriction that you may request. If the physician believes it is in your best interest to permit use and disclose of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically. You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made if any, of your protected health information, we reserve the right to chance the terms of this notice.

You then have the right to object or withdraw as provided in his notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a claim.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with the clinic manager.

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Notice of Privacy Practices and subsequent changes in office policy. I understand that this consent shall remain enforced from this time forward.

_____

Patient's Signature Date

Date of Birth: _____/_____/_____
Month Day Year

Manatee County Government Release of Information

Turning Points receives funding from Manatee County Government for various programs. As a client of Turning Points, your signature below certifies that you understand the following statements:

1. I understand that the County's Representative may request access to any or all Turning Points records related to the delivery of County funded programs and/or the delivery of services for the purposes of evaluating or monitoring the program or delivery of service to the client, and that I consent to the release of records for these purposes on behalf of myself and my household.
2. I understand that to the extent the records are provided to the County, they may become public records and may, subject to any applicable state or federal exemptions, be inspected or copied by third persons.

By signing below, I certify that I understand and consent to the above statements. This consent will remain in place for a period of one (1) year from the date indicated below. I understand that I may revoke this consent in writing at any time.

Printed Name: _____

Signature: _____

Date: _____

Divulgación de Información al Gobierno del Condado de Manatee

Turning Points recibe fondos del gobierno del condado de Manatee para varios programas. Como cliente de Turning Points, su firma a continuación certifica que comprende las siguientes declaraciones:

1. Entiendo que el Representante del Condado puede solicitar acceso a cualquiera o todos los registros de Turning Points relacionados con la entrega de programas financiados por el Condado y/o la entrega de servicios con el fin de evaluar o monitorear el programa o la entrega del servicio al cliente, y que doy mi consentimiento para la divulgación de registros para estos fines en mi nombre y el de mi familia.
2. Entiendo que, en la medida en que los registros se proporcionen al Condado, pueden convertirse en registros públicos y, sujeto a las exenciones estatales o federales aplicables, pueden ser inspeccionados o copiados por terceros.

Al firmar a continuación, certifico que entiendo y acepto las declaraciones anteriores. Este consentimiento permanecerá vigente durante un período de un (1) año a partir de la fecha que se indica a continuación. Entiendo que puedo revocar este consentimiento por escrito en cualquier momento.

Nombre: _____

Firma: _____

Fecha: _____

Revised 12/19/2022

Suncoast Continuum of Care

RELEASE OF INFORMATION

Authorization to Use or Disclose Personal Information including Protected Health Information (PHI)

Name:	Social Security Number:	Date of Birth:
Name of Provider Agency:		

I authorize the use or disclosure of personal information, including protected health information, about the individual named above.

I am: ☐ the individual named above
☐ a personal representative because the person is a minor, incapacitated, or deceased

_____ participates in the Sarasota/Manatee Continuum of Care (FL-500) coordinated entry system (Oneby1) and/or the Community Services Information System (CSIS). These systems include organizations that provide homeless and housing assistance and supportive services. As part of CSIS and the Oneby1 system, agencies agree to share information about individuals and families with other agencies in order to coordinate services and help a household find and/or keep housing as quickly as possible.

The information to be disclosed may include personal information contained within the Community Services Information System, records from providers detailing my medical conditions and including information on disabilities, mental health, drug abuse, alcoholism, sickle cell anemia, human immunodeficiency virus (HIV) infection, AIDS, and other communicable disease test results and diagnoses. Information contained within the Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT), the Service Prioritization Decision Assistance Tool (SPDAT), other assessment forms, and other information collected as part of case management, case planning and case conferencing will be shared in CSIS and as it relates to the coordination of services for housing placement and stability.

Important Rights and Other Required Statements You Should Know

You can revoke this authorization at any time by writing to the Suncoast Partnership to End Homelessness, Inc., 1750 17th Street / K-1, Sarasota, FL 34234. If you revoke this authorization, it will not apply to information that has already been used or disclosed.

You have a right to a copy of this authorization once you have signed it. Please keep a copy for your records, or you may ask us for a copy at any time by writing to Suncoast Partnership to End Homelessness, Inc. 1750 17th Street / K-1 Sarasota, Florida 34234.

If you have any questions about anything on this form, or how to fill it out, we can help. Please call the Suncoast Partnership at 941-955-8987.

This authorization will expire two (2) years from the date this document was signed by the individual or personal representative below.

By signing this authorization, I am attesting that I understand: *(Initial each line)*

_____The reason I am being asked to release information.

_____My protected health information, including, but not limited to, mental health, drug & alcohol, HIV/AIDS information can be shared with partner providers and CSIS participating organizations. I understand that agencies participating may change from time to time and that a copy of the current list of agencies is available upon request from the Suncoast Partnership by calling 941-955-8987.

_____The CSIS operates over the internet and uses many security protections to ensure the complete confidentiality of my records.

_____Signing this authorization is voluntary, and I do not have to agree to authorize any use or disclosure. I understand that the ability to receive services or support is not conditioned upon authorizing this disclosure. However, by not giving authorization to share information, I may not be able to access housing help as quickly as possible and that some services that result from a coordination of activities between providers may be limited in availability. Some agencies require certain questions to be answered in order to determine eligibility for their projects.*

_____The providers that have access to my protected health information are prohibited from re-disclosing information outside of the terms of his release of information form, without my written authorization except as permitted by federal or state law.

Signature _____ Date (required) _____

Dependent(s) that the Legal Guardian Authorizes to Participate in the SMCSIS:

Name_____ DOB___/___/___ Name_____ DOB___/___/___

Name_____ DOB___/___/___ Name_____ DOB___/___/___

Name_____ DOB___/___/___ Name_____ DOB___/___/___

Signature of Personal Representative (if applicable)

Signature _____ Date (required) _____

Please describe your relationship to the individual and/or your legal authority to act on behalf of the individual in making decisions related to healthcare and services. You may be asked to provide us with the relevant legal document giving you this authority.

Relationship to the individual (required): _____

Signature of Witness

Signature _____ Date (required) _____

*Agencies may have additional requirements that must be agreed upon by the participant. If applicable, these requirements will be listed on page 3.

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Turning Points Medical and Dental Clinic
Consent for Electronic Communication

The Turning Points Medical and Dental Clinic communicates with patients by telephone, email, and voicemail. We respect your right to direct how we communicate Personal Health Information (PHI) and other information to you.

When you consent to communicate with Turning Points by email, text messages, voicemail, or answering machine, you accept the risk that these communications may not be encrypted and that the messages may be received or intercepted by individuals who are not authorized to receive your PHI. If a security breach occurs, Turning Points will not be responsible for any privacy or security breach which may occur through email, voicemail, or text messaging or telephone information which you have made available to the Turning Points Medical and Dental Clinic.

Please select what type of electronic communications you wish to receive by email, voicemail, or text messaging:

☐ I do not consent to receive any voicemail, email, or text messages.

☐ I consent to receive only appointments and scheduling information by:
Check All That Apply: ☐ Voicemail ☐ Email ☐ Text Messaging

☐ I consent to receive all communications regarding my diagnosis, medical condition, medical treatment, Physician referrals, scheduling, and appointments by:
Check All That Apply: ☐ Voicemail ☐ Email ☐ Text Messaging

I consent to the use of the following information:
PLEASE DO NOT USE YOUR WORK EMAIL ADDRESS OR PHONE NUMBER

Email Address: _____

Mobile Phone Number (Cell): _____

Patient Signature: _____ Date: _____

Alternate/Emergency Contact Information

I authorize _____ Relationship: _____ Date of Birth: _____
To receive PHI, Scheduling, or Appointment Information on my behalf by:
Check All That Apply: ☐ Voicemail ☐ Email ☐ Text Messaging

Email Address: _____ Mobile Phone Number: _____

Patient Signature: _____ Date: _____

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Turning Points Medical and Dental Clinic
Telemedicine/Telehealth Consent Form

1. I understand that Telemedicine/Telehealth involves the use of secure interactive videoconferencing technology, equipment, and devices that enable health care providers to deliver health care services to patients at offsite locations.
2. I understand that the Telemedicine/Telehealth visit will be done through a two-way video link utilizing a secure videoconferencing site. The health care provider will be able to see me and hear my voice and I will be able to see and hear the health care provider.
3. I understand that laws that protect privacy and the confidentiality of personal health care information also apply to Telemedicine and Telehealth.
4. I understand that there are potential risks to using this technology including service interruption, interception by unauthorized third parties, and technical difficulties.
5. I understand that if the equipment or connection is not adequate, the visit may be terminated by either party to the visit.
6. I understand that I have the right to refuse to participate or to terminate the visit at any time and neither my refusal nor termination of a visit will affect my future care at the Clinic.
7. I understand that the visit and the consent form will be a part of my medical record.

_____ _____ _____

Signature Printed Name Date

Turning Points Grievance Policy

As a client of Turning Points, you have the right to file a complaint, grievance, and appeal if you are not satisfied with any action taken, staff decision, or if you believe you have experienced discrimination or abuse. The following procedures are intended to provide an effective, impartial, and expedited process to resolve differences in a manner that is satisfactory to all parties. All documentation related to a grievance or appeal will be maintained in a separate file for quality assurance review.

1. Complaint – Prior to filing a formal Grievance, you should bring your concern to the attention of the staff member involved, in an attempt to resolve the issue. A complaint may be verbal or written and must be logged according to agency policy, whether received by phone, in person, or in writing. Upon request by you or the staff member, the staff member's supervisor may be present for the discussion.

2. Grievance – If the situation is not resolved, a grievance must be submitted within two (2) business days in order to request further review of your complaint. The steps of the grievance process are as follows:
    a. You describe your concern in writing and submit it to the staff member's supervisor.
    b. The supervisor will contact you to discuss the grievance.
    c. Within five (5) business days of the discussion, a written explanation of decision, including any actions taken, will be sent to you.

3. Appeal – If the decision is not satisfactory, you may appeal to seek a secondary review. The steps of the appeal process are as follows:
    a. You describe your concern in writing and submit to the Executive Director.
    b. The Executive Director will contact you to discuss the appeal.
    c. Within five (5) business days of the discussion, a written explanation of decision, including any actions taken, will be sent to you.

My signature below acknowledges that I have read and understand the Turning Points Grievance Policy.

_____ _____/_____/_____

Signature Date

_____

Printed Name

(Revised April 2020)

FOR OFFICE USE ONLY / PARA USO DE LA OFICINA				
Status ☐ Application ☐ Renewal	Date Requested/Issued	Date Received	Case/Record Number	Appointment Date and Time, if applicable

APPLICATION FOR HEALTH CARE ASSISTANCE / SOLICITUD DE ASISTENCIA DE ATENCIÓN MÉDICA

Name (Last, First, Middle)/Nombre (Apellido, primer, segundo)	Home Telephone No./Teléfono de la casa	Other Telephone No./Otro número de teléfono

Have you ever used another name? If so, list other names you have used./¿Ha usado alguna vez otro nombre? Sí es el caso, enumere los nombres que ha usado.

☐ Yes/Sí ☐ No

Mailing Address (Street or P.O. Box)/Dirección Postal (Calle o Apdo.)	Apt.# /Apto.#	City/Ciudad	State/Estado	ZIP

Home Address, if different from above. If it is rural, give directions. / Domicilio particular, si es diferente a la dirección de arriba. Si es rural, explique cómo llegar.

Quick Eligibility Checklist:

1. Does the applicant have insurance or a form of third-party coverage? ☐ Yes ☐ No
   (I.e. Medicare, Health Insurance, Medicaid, V.A., Tricare etc.).
2. Is this related to worker's compensation? ☐ Yes ☐ No

Quick Medicaid Eligibility Checklist:

1. Is the applicant a minor, under 18? ☐ Yes ☐ No
2. Does the applicant have minor children or step-children under the age of 18 in the home? ☐ Yes ☐ No
3. Is the applicant pregnant? ☐ Yes ☐ No
4. Is the applicant over the age of 65? ☐ Yes ☐ No
5. Does the applicant have a long-term disabling condition? ☐ Yes ☐ No

If the answer is 'yes' to any of the above questions, the patient may be eligible for Medicaid. The patient must submit a Medicaid denial letter Prior to being considered for the Manatee County Health Care Program (MCHCP).

1. **On the chart below, fill in the first line with information about yourself. Fill in the remaining lines for everyone who lives in the house with you, whether or not you consider them family unit members.** / En la tabla a continuación, llene la primera línea con información acerca de usted mismo. Llene las líneas restantes acerca de todos que viven en la casa con usted, los considere miembros de la unidad familiar o no.

The phrase "Family Unit" refers to you, your spouse, dependent children, step-children, parents (for clients under the age 22), adoptive parents/children, unborn children (an unborn child of a pregnant mother counts individually as a family member). La frase "unidad familiar" se refiere a usted, su cónyuge, hijos dependientes, hijastros, padres (para los clientes bajo la edad de 22 años), los padres adoptivos / los niños, los niños no nacidos (un niño no nacido de una madre embarazada cuenta individualmente como un miembro de la familia).

Name (Last, First, Middle) Nombre (Apellido, primero, segundo)	**Sex** Sexo **Male/ Female** Hombre/ Mujer	**Date of Birth** Fecha de nacimiento	**What Relation to you?** ¿Parentesco con usted?	**Are you a U.S. Citizen or an alien lawfully admitted for permanent residence?** ¿Es usted un ciudadano de Estados Unidos o un extranjero lefalmente admitido para residencia permanente? N/A
			MYSELF Yo mismo	

2. **List all of your household's income below. Income is all household income available to the household annualized by verification of the last 3 months of income (x4), all income verified for the last 12 months or the most recent tax return. This includes gross wages, gross salaries, net income from self-employment, child support, alimony, unemployment compensation, worker's compensation, veteran's pension benefits, social security, pensions, annuities, dividends, interest income, income from estates and trusts, net rental income, royalties, contributions from individuals or organizations, other income not mentioned above./** El ingreso es el ingreso familiar total disponible para el hogar anualizada de verificación de los últimos 3 meses de renta (x4), todos los ingresos verificado durante los últimos 12 meses o la más reciente declaración de impuestos. Esto incluye los salarios brutos, salarios brutos, los ingresos netos de trabajo por cuenta propia, manutención de hijos, pensión alimenticia, compensación por desempleo, compensación al trabajador, beneficios de pensión de veteranos, seguridad social, pensiones, anualidades, dividendos, ingresos por intereses, ingresos de sucesiones y fideicomisos, alquiler neto renta, regalías, aportes de individuos u organizaciones, otros ingresos no mencionados anteriormente

Name of person receiving money Nombre de la persona que recibe el dinero	**Name of agency, person, or employer who provides the money** Nombre del patrón, la persona o la agencia que paga el dinero	**Amount received** Cantidad recibida	**How often received? (daily, weekly, every two weeks, twice a month, monthly?)** ¿Con qué frecuencia lo recibe? (¿diariamente, por semana, cada quincena, dos veces al mes, una vez al mes?)

The statements I have made, including my answers to all questions, are true and correct to the best of my knowledge and belief.

I agree to give eligibility staff and the county any information necessary to prove statements about my eligibility.

I agree to report any of the following changes within 14 days:

- **Income**
- **Number of people who live with me**
- **Address**
- **Application for or receipt of SSI, TANF, or Medicaid**

I have been told and understand that this application will be considered without regard to race, color, religion, creed, national origin, age, sex, disability, or political belief; that I may request a review of the decision made on my application or re-certification for assistance; and that I may request, orally or in writing, a fair hearing about actions affecting receipt or termination of health care assistance.

A mi leal saber y entender, las declaraciones que he hecho, y mis respuestas a todas las preguntas, son verdaderas y correctas.

Me comprometo a dar al personal que verifica la elegibilidad y al condado toda la información necesaria para comprobar mis declaraciones sobre la elegibilidad.

Me comprometo a avisar, dentro de los 14 días, de cualquier cambio de:

- Ingresos
- Recursos
- Número de personas que viven conmigo
- Dirección
- Solicitud de SSI, TANF, o Medicaid o la entrega de cualquiera de estas.

Me han dicho y comprendo que esta solicitud será considerada sin discriminación por raza, color, religión, credo, origen nacional, edad, sexo, discapacidad, ni afiliación política; que puedo pedir una revisión de la decisión que se haga acerca de mi solicitud de asistencia o recertificación para asistencia; y que puedo pedir, oralmente o por escrito, una audiencia imparcial sobre cualquier acción que afecte la entrega o la terminación de asistencia de atención médica.

I understand that by signing this application, I am giving the county the right to recover the cost of health care services provided by the county from any third party. I agree to give the county any information it needs to identify and locate all other sources of payment for health care services.

I have been told and understand that my failure to meet the obligations set forth may be considered intentional withholding of information and can result in the recovery of any loss by repayment or by filing civil or criminal charges against me.

Comprendo que al firmar esta solicitud, doy al condado el derecho a recuperar de cualquier tercero el costo de los servicios médicos proporcionados por el condado. Me comprometo a dar al condado la información necesaria para identificar y localizar cualquier otro fuente de pagos por mis servicios médicos.

Me han dicho y comprendo que si dejo de cumplir con las obligaciones especificadas en ésta podría considerarse como una retención intencional de información y podría dar lugar a la recuperación de pérdidas por medio de la devolución de pagos o por medio de la presentación de cargos criminales en mi contra.

BEFORE YOU SIGN, BE SURE EACH ANSWER IS COMPLETE AND CORRECT.
ANTES DE FIRMAR, ASEGÚRESE DE QUE CADA RESPUESTA SEA COMPLETA Y CORRECTA.

Signature – Applicant / Firma – Solicitante	**Date** / Fecha	**Signature – Spouse** / Firma – Esposo o Esposa	**Date** / Fecha

If the applicant is married and his/her spouse is a household member, the spouse may also sign and date this Form even if the spouse is a disqualified household member. Si el/la solicitante está casado/a y su esposo o esposa vive en la misma casa, el cónyuge también puede firmar que su esposo o esposa también firme esta Forma, aunque no tenga derecho de recibir asistencia.

Signature - Person Who Helped Complete This Application / Date Firma - Persona que ayudó a llenar esta solicitud / Fecha	**Signature - Applicant's Representative / Date** Firma – Representante del solicitante / Fecha	**Signature – Witness (if signed with "X") / Date** Firma – Testigo (si firma con "X") / Fecha

Address (Street, City, State, ZIP) and telephone number of anyone who helped complete this Form 100/Dirección (Calle, Ciudad, Estado, ZIP) y teléfono de la persona que ayudó a llenar esta Forma 100

MANATEE COUNTY BOARD OF COUNTY COMMISSIONERS

AUTHORIZATION FOR RELEASE OF INFORMATION
FOR MANATEE COUNTY HEALTH CARE PROGRAM

Community Services Department
P.O. Box 1000
Bradenton, FL 34206

I hereby grant permission and authorize any Federal, State or local social services agency, bank, savings association, employers, landlord, insurance company, real estate company, utility company, or any financial institution of any kind or character to disclose to any employee of the Manatee County Community Services Department and/or medical provider participating in the Health Care Program, full information as to past, present, or future benefits assistance, accounts, earnings, insurance policies, property, or other assets for me or my immediate family. A copy of this authorization shall be considered as effective and valid as the original. This authorization shall be in effect for six months from the date below.

_____ _____

APPLICANT'S SIGNATURE DATE

_____ _____

WITNESS SIGNATURE DATE

Patient Name (Last, First): _____

Medical Health History

I. Employment

Patient's Employer: _____

Employment Status: ☐ Full Time ☐ Part-Time ☐ Retired ☐ Student ☐ Other: _____

II. Emergency

Emergency contact: _____ Relationship: _____

Address: _____ Phone number: _____

III. Medical Information

Please list any MEDICATIONS you are currently taking, prescribed or over the counter (use the back of this page if needed):

Medication	Dosage	How is it taken?	How often?

Any Allergies to Medication or Food (list reactions):

_____

Preferred Pharmacy: _____

Patient Name (Last, First): _____

If YOU or a FAMILY MEMBER has had any of the following, please check and indicate which family member when applicable:

Condition	Family Member
☐ ADD/ADHD	
☐ Anemia	
☐ Allergies/Hay Fever	
☐ Asthma	
☐ Arthritis/Gout	
☐ Anxiety/Depression	
☐ Addiction (specify):_____	
☐ Blood Clots	
☐ Cancer, Type/s: _____	
☐ Chest Pain	
☐ Diabetes	
☐ Fractures	
☐ Gynecological Disease	
☐ Headaches	
☐ Hepatitis C or HIV (circle)	
☐ High Blood Pressure	
☐ Heart Attack	

Condition	Family Member
☐ High Cholesterol	
☐ Kidney Disease	
☐ Liver Disease	
☐ Neurological Disease	
☐ Osteopenia/Osteoporosis	
☐ Respiratory Disease	
☐ Sickle Cell Anemia	
☐ Skin Disease	
☐ STDs	
☐ Stomach/Colon Disease	
☐ Stroke	
☐ Seizure Disorder	
☐ Thyroid Disorder	
☐ Urinary problems	
☐ Vision Problems	
☐ Other: _____	

Please list any SURGERIES you have had and include the month/year:

_____

_____

IV. Dates

Last Complete Physical Exam:	
Last Blood Work:	
Last Colonoscopy:	
Last Tetanus Shot:	

Patient Name (Last, First): _____

V. Female

Last Menstrual Period (Females only)	
Last Pap Smear (Females only)	
History of Abnormal Pap (dates) (Females only)	
Last Mammogram (Females only)	
DEXA (Females only)	
Number of Pregnancies: (Females only)	
Miscarriages: (Females only)	
Terminations: (Females only)	
Living Children: (Females only)	
Methods of contraception: (Females only)	

VI. Social Information

Tobacco Use :	
Do you smoke? ☐ Yes ☐ No	If yes, how many cigarettes/cigars per day?
No. of years smoking?	
Do you chew tobacco?	Have you thought about quitting?
Have you quit before?	How long?

Alcohol Use:	
Do you drink alcohol? ☐ Yes ☐ No	If so, what type?
How many in 1 week?	Ever sought help?

Drug Use:	
Any history of illegal drug use? ☐ Yes ☐ No	If so, what type/s?
When?	Ever sought help?

Physical Activity:	
Do you Exercise? ☐ Yes ☐ No	
Are you on any special diet?	If so, what?
Do you consume any caffeinated products? ☐ Yes ☐ No	If so, how much per day?

Patient Name (Last, First): _____

Dental History

Please check any of the following problems that apply to you:

☐ Sensitivity (hot; cold, sweet)
Where? _____
☐ Headaches, neck pain
☐ Jaw joint pain
☐ Teeth or filling breaking
☐ Grinding or clenching teeth
☐ Bleeding, swollen or irritated gums
☐ Loose, ripped or shifting teeth
☐ Bad breath

ON A SCALE OF 1-10, WITH 10 BEING THE HIGHEST RATING:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be?

1 2 3 4 5 6 7 8 9 10

Please share the following dates:

- Your last cleaning _____/_____
- Your last oral cancer screening _____/_____
- Your last complete X-Rays _____/_____

ALLERGIES: _____

Dentist Signature: _____ Date: _____

First Name: _____ M.I. _____ Last Name: _____

Address: _____
(Street Address)

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

Social Security Number: _____ - _____ - _____ ☐Don't Know ☐Refused to Answer ☐Don't Have One

U.S. Military Veteran? ☐Yes ☐No

Do you have Medical Insurance? ☐Yes ☐No

Date of Birth? _____
Month/Day/Year

Do you have Dental Insurance? ☐Yes ☐No

Marital Status? ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Gender? ☐Male ☐Female ☐Transgender ☐Male to Female ☐Female to Male ☐Non-Binary

Primary Race(s)? ☐Native American ☐Asian ☐Alaskan Native ☐Pacific Islander ☐Black ☐White ☐Other

Ethnicity? ☐Hispanic ☐Non-Hispanic

Head of Household? ☐Self ☐Other

Last Known Zip Code: _____

Are you Homeless? ☐Yes ☐No

Living Situation: ☐Own my residence ☐Rent ☐Staying with Family
☐Staying with a Friend ☐Other: _____

Length of Stay in Current Residence:
- ☐ One week or less
- ☐ More than one week, but less than a month
- ☐ One to three months
- ☐ More than three months, but less than a year
- ☐ One year or more
- ☐ Do not know
- ☐ Refused to answer

Do you have any disabling conditions?
(Please, select all that apply)
- ☐ Drugs
- ☐ Alcohol
- ☐ Drugs and Alcohol
- ☐ Physical
- ☐ Mental
- ☐ Other: _____

Number of times you have been homeless, on the streets, or in a shelter in the past 3 years: _____

Number of months you have been homeless, on the streets, or in a shelter in the past 3 years: _____

Do you receive Food Stamps (SNAP benefits)? ☐Yes ☐No

Do you have children living in the household? ☐Yes ☐No Number of children: _____

Are you currently working? ☐Yes ☐No Gross Income (Before Taxes Are Taken Out): _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone Number: _____