Patient Registration Paperwork

We look forward to assisting you!!

Main Location:	Farmington Location:	School-Based Services
#1 Southtowne Dr	508 West Pine St	Call (573) GET-WELL
Potosi, MO 63664	Farmington, MO 63640	438-9355
(573) 438- 9355	(573) 664-1100	

School Based Health Center Fact Sheet

What is a School Based Health Center?

School-Based Health Centers are health clinics that bring preventive and immediate care, as well as counseling, health education, and sometimes dental care, to children and adolescents at schools.

Hours & Coverage: The SBHC is open when school is in session. Please call for hours. Although appointments are preferred, students may be seen on a walk-in basis, depending on the problem and availability of the staff. If necessary, appointments are available before or after school. If a student or parent does not have a primary care provider he/she will have phone access to health care providers during the evening, weekends and vacations by dialing the GMHC main number phone number 573-438-9355. A recorded message will direct the caller to the provider on call.

Staffing: The staff at Great Mines Health Center's SBHC are highly qualified and experienced in providing health care to young people. The Nurse Practitioner, Dental Hygienist and Licensed Clinical Social Worker work in collaboration with a physicians and dentists and are qualified to diagnose and treat a variety of healthcare needs. The Nurse Practitioner is able to prescribe medications. The SBHC staff work with, but do not replace your family doctor or school nurse, however Great Mines Health Center would be happy for you to become an established medical, dental or behavioral health patient of the health center!

Billing & Costs: No student will be denied access to health care services due to inability to pay at the time of service. As in any health center, there may be a charge depending on the service provided and the parents or guardians will be billed for their child's treatment and will be responsible for payment. Patients/parents are responsible for insurance co-pays and unmet deductible amounts. Students eligible for the free/reduced lunch program may qualify for CHIPS or Medicaid. Information about various programs and how to apply is available from the health center staff. The SBHC depends upon the ability to collect payment from your insurance carrier in order to maintain the current hours of the SBHC.

Patient Registration Paperwork

You will need to present a copy of the following at your First and Annual visits:

- ☐ Driver's License or Photo Id
- ☐ Insurance Cards
- ☐ Signed Registration Forms
- ☐ Sliding Scale Application and income verification, if applicable
- ☐ Copays
- ☐ Proof of Address

Proof of Address: current utility bill, Piece of mail addressed to you (within 30 days), Paystub with current mailing address, any government mail (Social security, Pension etc.), lease or mortgage agreement.

Proof of Income: If you do **NOT** carry insurance or choose to not use your insurance please be sure to provide us with your proof of household income.

Please provide all Household Income that applies:

- ☐ Current Check Stub, W2, Current Tax Return, or company letterhead stating: Hourly rate of pay, gross pay and the pay period.
- ☐ Social Security, Child Support, SSI Disability award letter, or Food Stamp Summary (Must show total gross income)
- ☐ Current unemployment determination letter

Who does GMHC define as "Family/Household"?

- ☐ Husband, Wife and dependent Children (any age, related biologically or adopted)
- ☐ Significant Other
- ☐ Unmarried Partners
- ☐ Mother/Father if included on the tax return
- ☐ Grand Parents if included on the tax return
- ☐ Grand Children if included on the tax return
- ☐ All members included on the tax return

**I understand if I do not provide the above information within thirty (30) days from today, I will be fully responsible for all services rendered and these services will be billed at the full price until information is returned.*

Patient Registration Paperwork

Great Mines
HEALTH CENTER

I am interested in the following GMHC services offered at the School District:

Medical ☐ **Dental** ☐ **Behavioral Health** ☐

Great Mines Health Center
REGISTRATION FORM
Please Print

Today's Date:	Preferred Provider:	Preferred Pharmacy:

PATIENT INFORMATION

Patient's Last Name: First: Middle:			Circle One: Mr. Mrs. Miss. Ms. Marital Status: Circle One Single / Mar / Div / Sep / Wid
Is this your legal name? Yes or No	If No, what is your legal name?		Former Name:
Date of Birth:MM/DD/YYYY	Age:	Sex at birth: M / F	Social Security Number:
Street Address: (PO Box)		City, State & Zip:	
Home Phone: ( )	Cell Phone: ( )	Email:	Contact Preference: Circle One Home / Cell / Email
Appointment reminders: Y / N Text: _____ Or email_____	Driver License #		Driver License State:
Occupation:	Employer:		Employer Phone: ( )

Preferred Language: English, Spanish, other_____ **Race**: White, Black, Hispanic, other _____

US Military Veteran: Y or N **Do you have an advanced directive:** Y or N

Sexual Orientation: Prefer not to disclose Lesbian/Gay/Homosexual/Straight/Heterosexual/Bisexual/Don't know

Gender Identity: Male/Female/Transgender Male/Female to Male Female/Male to Female

Housing Status: NOT Homeless/ Homeless/Public Housing/Doubling Up/Transitional Housing

Responsible Party Information

Responsible Party, First, M.I. and Last Name:	Date of Birth:	Relationship to Patient:	current patient? Y or N
Street Address, City, State & Zip: (If Different)			
Occupation:	Employer:	Employer Phone:	

SUBSCRIBER'S INFORMATION: Medical Insurance ☐ Dental Insurance ☐

Name of Insured:	Social Security:	Date of Birth:	Relationship to Patient:
Insurance Company Name:	Group Number:	Policy Number:	
Employer Name:	Co-Payment: $	Rem. Benefits $	Rem. Deductible: $

SUBSCRIBER'S INFORMATION: Medical Insurance ☐ Dental Insurance ☐ Secondary ☐

Name of Insured:	Social Security:	Date of Birth:	Relationship to Patient:
Insurance Company Name:	Group Number:	Policy Number:	
Employer Name:	Co-Payment: $	Rem. Benefits $	Rem. Deductible: $

SUBSCRIBER'S INFORMATION: Medical Insurance ☐ Dental Insurance ☐ Secondary ☐

Name of Insured:	Social Security:	Date of Birth:	Relationship to Patient:
Insurance Company Name:	Group Number:	Policy Number:	
Employer Name:	Co-Payment: $	Rem. Benefits $	Rem. Deductible: $

EMERGENCY CONTACT

Name:	Relationship to Patient:	Home Phone:	Cell Phone:	Work Phone:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to GMHC. I understand that I am financially responsible for any co-pays and/or any remaining balance not paid by my insurance company. I also authorize Great Mines Health Center or insurance company to release any information required to process my claims.

Patient/Guardian Signature	*Date:*

Revised 8-6-19

Consent and Authorization Form

Consent to Treatment

I hereby grant permission for Great Mines Health Center (GMHC) to perform those procedures and treatments deemed necessary or advisable for complete care of myself or a dependent for whom I am legally responsible. I authorize any GMHC licensed provider, or auxiliary to perform any treatment, medication administration and therapy that may be indicated in connection with my care or the care of my dependent. I understand that before treatment, full explanation of the procedure(s) involved will be given by staff.

Authorization and Release

I authorize GMHC to release any information, including the diagnosis and the records of any treatment or examination provided to me or my dependent during the period of such care, to third party payers and /or health practitioners. I understand this may include information regarding HIV, AIDS, Alcohol or drug abuse, mental illness or any mental health condition, sexually transmitted diseases, family planning, pregnancy, genetic tests or genetic diseases.

Persons Authorized to Receive Information:

Health information that Great Mines Health Center collects or receives about me may be disclosed to the following persons:

_____

Name of Person **Relationship** **Phone Number**

_____

Name of Person **Relationship** **Phone Number**

(Please Initial) GMHC representatives may leave a detail message on answering machine: Yes_____ No_____

(Please Initial) I authorize GMHC to release an excuse to my work/school: Yes_____ No_____

Financial Consent

I authorize and request my insurance company to pay directly to Great Mines Health Center. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services provided on my behalf or my dependents. If my account balance is sent to an outside agency for collection, I am responsible for collection fees that must be paid to said agency. *I am aware, that patients will be assessed a $25 fee for checks returned due to Insufficient Funds, a missed appointment fee of $5 for second missed appointment, $10 for third missed appointment, and $20 for each appointment missed thereafter for a three-year time period. Missed appointment fee will be charged if a 24-hour notice of cancellation is not given.* ***No controlled medication will be refilled if fee is not paid and patient will be walk-in only until fee is paid.***

Photographic Consent

I agree that photographs of me or my dependent may be taken by a member of Great Mines Health Center staff. The photograph(s) will be used for medical records and to help in the avoiding Identity Theft. All photographs are strictly private, and the identity of the patient will not be revealed to anyone outside of Great Mines Health Center unless required by law enforcement.

I further authorize, GMHC, to use radiographs, treatment records, and other diagnostic materials for the purpose of teaching, research, and scientific publications with the assurance that my or my dependent's identity will remain confidential. Opt out:_____

Notice of Privacy Practices

We are committed to protecting your personal health information in compliance with the law. We are required by law to give you a copy of this notice, if requested. A copy of GMHC's HIPAA Notice of Privacy Practices are posted in the main lobby and available for me to read in its entirety. If you choose to receive information from Great Mines Health Center via email or text (e.g. appointment reminders), it will be sent through a secure server. However, you will be responsible for the protection of that information once it leaves our server. The HIPAA Notice of Privacy Practices contains information on the uses and disclosures of my protected health information ("PHI").

Patient's Name (please print) _____Date Of Birth_____

Signature of patient or patient representative_____

Print name and Relationship to Patient_____ Date_____

***This signed consent, authorization and acknowledgment is effective until treatment is terminated in writing by you, the patient, or* GMHC**

***IF APPLICABLE - School Based Clinic (SBHC) Location – additional consent to treatment, authorization and release**

I, the parent/guardian of said student, give consent for my child to receive services at GMHC SBHC. I understand that this consent form will be effective until my child leaves or graduates from the District, or until I provide the Center staff with written revocation of this consent. All healthcare information is confidential. By signing the consent form you are giving the SBHC and your child's regular doctor (if applicable) permission to communicate and share healthcare information regarding your child's medical, dental, or mental health, condition on an as needed basis with the understanding that this information will continue to be treated in a confidential manner. No student will be denied access to health care services due to inability to pay at the time of service. I agree to all other terms listed as above. Confidentiality between the student, parents and the health center is assured. I understand that if guardianship changes a new consent must be signed by the legal guardian.

Signature:_____ Date_____ School District SBHC:_____

Sliding Fee Discount Application

It is the policy of Great Mines Health Center to provide primary care services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic, but not those services or equipment that are purchased from outside entities, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. This form must be completed every 12 months or if your financial situation changes.

Please initial what applies to you:

1. _____ I am a new patient with GMHC, I do not have insurance and I did not bring my proof of income. This form serves as a Self-Statement of income for my first New-Patient visit only. *I am aware I have 30 days to return proof of income*
2. _____ I am an established patient at GMHC and recently lost my insurance coverage. This form serves as a Self-Statement of income for today's visit only. *I am aware I have 30 days to return proof of income*
3. _____ I have insurance but would like to submit this application for any services not covered by my insurance company and/or for services that I choose to not submit to my insurance company. *I am aware I have 30 days to return proof of income*

Head of Household: Yes or No Name of Head of Household _____

Address:_____
Street City, State, Zip

Place of Employment:_____

RELATIONSHIP	**NAME**	**DATE OF BIRTH**	**PHONE**	**Currently a GMHC Patient Y/N**
SELF				
SPOUSE				
DEPENDENT				
DEPENDENT				
DEPENDENT				
DEPENDENT				
DEPENDENT				

Great Mines
HEALTH CENTER

Sliding Fee Discount Application

Annual Household Income – Based on Annual compensation

SOURCE	SELF	SPOUSE	DEPENDENT/OTHER	TOTAL
Gross wages, salaries, tips, etc.				
Income from business/self-employment				
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				
TOTAL INCOME				

I, the person who has signed below, have filled out this application for the Sliding Fee Discount consideration and can prove that this information is true and correct, to the best of my knowledge. I am also aware that if there is any change in financial status of any of the people in my household it must be report immediately to Great Mines Health Center, (GMHC) and a new application must be filled out. I understand that, upon request of GMHC, and yearly, there will be a review of my application with the chance of discount amount changes. I understand that any untrue information written on form or the failure to provide proof of income within 30 days may result in my being made not qualified for the Discount Fee reduced priced made available by GMHC. I also understand this discount service is for services provided within GMHC only!

Applicants Signature:_____Date:_____

As a Federally Qualified Health Care Center we are required to collect certain information. The information on this form is used to determine the amount of discount that you may receive from GMHC and/or for statistical purposes. I understand that my personal or financial information will not be released.

BELOW TO BE COMPLETED BY GMHC STAFF ONLY

Witness By (GMHC Representative):_____Date:_____
_____Approved_____% of discount Sliding Scale_____Annual Expiration Date:_____
Provision, if any_____proof of income Verified _____30 day Expiration date:_____
_____Disapproved Reason:_____
_____Pending Reason:_____
Proof of Address Verified_____ Photo Id on File_____
Certified By:_____Date:_____

Patient Registration Paperwork

Great Mines
HEALTH CENTER

Medical / Behavioral Services Paperwork:

Pediatric Past Family and Social History
5 years and up

Date:_____Patient Name:_____DOB:_____SEX: □M □F

Date on Immunizations: Yes or No (Please make sure the office has an updated copy)

If not please state why: _____

Child Social History

Parent Information: *(circle all that apply)*

Parents together	Father Involved	Same Sex Partners
Parents separated	Mother Involved	Foster Care
Lives w/Mother	Father not Involved	Guardian Parents (Clarify):_____
Lives w/Father	Mother not Involved	Other (Clarify): _____

Is the patient adopted □ Yes □ No **Is the patient in foster care □ Yes □ No**

Parents Smoke: *(circle all that apply)* Yes No Outside Only

Pets (What Kind, How Many, Inside or Outside): _____

Name of School/Preschool/Daycare: _____

Has the patient ever received anesthesia □ Yes □ No **Any family history of anesthesia reactions □ Yes □ No**

Does the patient currently have an Epi Pen □ Yes □ No □ Not Applicable

Patient Medical History: Please circle Yes or No, if Yes please provide details

If the patient is adopted or in foster care please include any known medical history below

			Past or Current Diagnosis	Physician Name or Name of Facility
Cancer	No	Yes		
Blood Disorder	No	Yes		
Diabetes	No	Yes		
Endocrine/Metabolic Disorder	No	Yes		
Ear, Nose, & Throat Disorder	No	Yes		
Cardiovascular Disorder	No	Yes		
GI/Stomach Disorder	No	Yes		
GU/Kidney Disease	No	Yes		
Musculoskeletal Disorder	No	Yes		
Neurological Disorder	No	Yes		
Psychiatric/Learning Disorder	No	Yes		
Respiratory/Asthma Disorder	No	Yes		
Skin Disease	No	Yes		
Other Chronic Problems	No	Yes		

Pediatric Past Family and Social History
5 years and up

MEDICATIONS: **Does the patient currently take any medications □ Yes □ No**
If you marked Yes, please list all prescription and non-prescription medications, vitamins, home remedies, birth control, herbs etc

Medication	Dosage	Directions/ Frequency	Medication	Dosage	Directions/Frequency
1.			**4.**		
2.			**5.**		
3.			**6.**		

HOSPITALIZATONS: **Has the patient ever been hospitalized □ Yes □ No**
If you marked Yes, please list the dates, the name of the hospital, the reason and how long they were there

Date (Month, Day, Year)	**Hospital Name**	**Reason or Diagnosis**	**How long where they there**

SURGICAL PROCEDURES: **Has the patient had any previous surgeries □ Yes □No**
If you marked Yes, please list the date of the surgery, name of the hospital where it was performed and the name of the procedure

Date (Month, Day, Year)	**Hospital Name**	**Surgical Procedure**	**Date** (Month, Day, Year)	**Hospital Name**	**Surgical Procedure**
1.			**4.**		
2.			**5.**		
3.			**6.**		

ALLERGIES: **Does the patient have any known allergies □ Yes □ No**
If you marked Yes, please list the date they were diagnosed, allergy name and the reaction type

Date (Month, Day, Year)	**Allergy Name**	**Reaction** (Ex: anaphylactic shock, rash, diarrhea)	**Severity** (Ex: Mild, Moderate, Severe)

Does the patient currently have an Epi Pen □ Yes □ No □ Not Applicable

Dental History: Name of Dentist:_____Date of last exam: _____

Vision History: Name of eye care facility:_____Date of last exam:_____
Currently wear glasses/contacts: □Yes □No

Pediatric Past Family and Social History
5 years and up

Education/School/Social History:

Name of School: _____ **Grade:** _____

School Performance: *(circle all that apply)*

Likes School Dislike School Advanced Program Honor Roll

Excellent Good Grades Grades are declining Struggling to keep up

School Issues/Concerns: *(circle all that apply)*

None Behavior Problems Non Attendance Expelled Suspended

Peer Interactions: *(circle all that apply)*

Makes friends easily Has good group of friends Tends to keep to self Fights with other children

Has trouble making/keeping friends Bullied/picked on by other children Bossy/picks on other children

Extracurricular Activities: *(circle all that apply)*

Baseball/Softball Basketball Soccer Martial arts Dance/cheer Plays musical instrument

Sings in choir Art or drama Scouts Church group Gymnastics Taekwondo Track/Cross Country

Other: _____

Does the patient currently receive any academic assistance at school □ Yes □ No if Yes please provide details

_____

Menstrual History: (Only required for Adolescent girls)

Has the patient started her period □ Yes □ No (if yes please answer the questions below)
What age did the patient start:_____Is the cycle regular or irregular: _____
How long does the cycle last:_____How is the flow (Excessive, Heavy, Minimal):_____

Smoking Status: (Only required for patient 13 years and older)

Is the patient a former or current smoker □ Yes □ No (if yes please answer the questions below)
Does or did the patient smoke light, hand-rolled, natural, or herbal cigarettes □ Yes □ No
How many per day or how many packs:_____Age started_____Age stopped _____
Does or did the patient smoke Bidis(flavored cigarettes), Clove cigarettes (Kreteks) □ Yes□ No How many per day or how many packs:_____Age started_____Age stopped _____
Does or did the patient smoke cigars, little cigars, Cigarillos, or Blunts □ Yes □ No
How many per day or how many packs:_____Age started_____Age stopped_____
Does or did the patient smoke a pipe, water pipe or Hookah □ Yes □ No
How many pipes a day:_____Age started_____Age stopped _____
Does or did the patient smoke a Electronic Cigarettes or E-Cigarettes □ Yes □ No
How many per day or how many packs:____Age started___Age stopped _____ **Does or did the patient use Smokeless Tobacco, Chew Tobacco, Snuff, and Snus □ Yes □ No** How many times per day:_____Age started_____Age stopped __

Sexual History: (Only required for Adolescent patient)
Is the patient currently sexual active □ Yes □ No (if yes please answer the questions below) **How many sexual partners have they had:_____Do they use protection:** _____
Has the patient ever had an STD (Sexual Transmitted Disease) □ Yes □ No
GIRLS: Is the patient on birth control □ Yes □ No

Pediatric Past Family and Social History
5 years and up

Great Mines
HEALTH CENTER

FAMILY HISTORY: Please indicate with a check (√) if the patient's family has had any of the following conditions and then specify in the box their diagnosis. In the second column please indicate their living status. L = Living, D = Deceased, U = Unknown. **If the patient is adopted or in foster care please include any known family medical history below**

	Date of Birth	Living Status	Cancer	Diabetes	Heart Disease	Eye Disorder	Ear Disorder	Respiratory Disorder	GI Disorder	GU Disorder	Muscle Disorder	Neurological Disorder	Psychiatric Disorder	Skin Disease
Mother			□	□	□	□	□	□	□	□	□	□	□	□
Father			□	□	□	□	□	□	□	□	□	□	□	□
Sibling			□	□	□	□	□	□	□	□	□	□	□	□
Maternal Grandma			□	□	□	□	□	□	□	□	□	□	□	□
Maternal Grandpa			□	□	□	□	□	□	□	□	□	□	□	□
Paternal Grandma			□	□	□	□	□	□	□	□	□	□	□	□
Paternal Grandpa			□	□	□	□	□	□	□	□	□	□	□	□
Maternal Aunt			□	□	□	□	□	□	□	□	□	□	□	□
Maternal Uncle			□	□	□	□	□	□	□	□	□	□	□	□
Paternal Aunt			□	□	□	□	□	□	□	□	□	□	□	□
Paternal Uncle			□	□	□	□	□	□	□	□	□	□	□	□

Please list any other family medical history:

History Completed By: _____

Informed Consent for Telehealth Consultation

To serve the needs of people in the community, health care services are now available by interactive video communications and/or by the electronic transmission of information. This may assist in the evaluation, diagnosis, management, and treatment of a number of health care problems. This process is referred to as “telemedicine” or “telehealth.” This means that you may be evaluated and treated by a health care provider from a distant location. Since this may be different from the type of consultation with which you are familiar, it is important that you understand and agree to the following statements.

1. I understand that my health care provider recommends that I engage in telehealth consultation (“consulting provider”) with Great Mines Health Center.

2. I understand that the consulting provider will be at a different location from me. A health care provider (“presenting provider”) may be present with me in the room to assist in the consultation.

3. I understand that I have the option to refuse telehealth service at anytime without affecting my right to future care or treatment and, if applicable, without risking the loss of or withdrawing from my participation in the MO HealthNet program.

4. I understand that there are alternatives to this telehealth consultation. I may have the option to travel to see the consulting provider, or I may refuse to see the consulting provider. Pathways has fully explained the alternatives to me.

5. I understand that I have the right to access my medical history, examinations, x-rays, tests, photographs or other images (“my medical information”) related to this consultation.

6. The presenting provider may transmit or share electronically my medical information with the consulting provider who is at a different location. I consent to this transmission, but I can request that my medical information not be sent to the consulting provider if I make the request before my medical information is transmitted.

7. The consulting provider may store or retain my medical information to comply with any applicable state or federal records retention requirements, but may not store or retain my medical information beyond these limits without my written permission.

8. I will be informed if any additional personnel are to be present with me in the room or in the room with the consulting provider. I will give my verbal permission prior to the entry of the additional personnel, and I can exclude anyone from being resent at any time during the consultation.

9. I understand that I have the right to be informed of and to object to the videotaping or other recording of this consultation. I acknowledge that Great Mines Health Center has explained the telehealth consultation in a satisfactory manner and that all questions that I have asked about the consultation have been answered in a manner satisfactory to me or to my representative.

Understanding the above, I consent to the telehealth consultation described above.

_____ _____

Name Date

To recipient of information: This information has been disclosed to you from records whose confidentiality is protected by state and federal law. These laws prohibit you from making any further disclosure of this information without the specific written consent of the person to who it pertains, or as otherwise permitted by law. A general authorization for release of medical or other information may not be sufficient.

Informed Consent for Telehealth Consultation

INFORMED CONSENT FOR DISCLOSURE OF CLIENT
INFORMATION FOR BEHAVIORAL HEALTH SERVICES

I, _____, authorize, Great Mines Health Center (Agency to provide treatment) to make disclosure of the specific information listed below in this document to:

_____
(Agency that provided previous treatment)
to:

_____
(Agency that provided previous treatment)

I authorize these agencies to communicate with and disclose to one another information about my symptoms, diagnosis, medications, chemical dependency information, and treatment plan. (May also include information about sexually transmitted disease (STD) testing and treatment, HIV/AIDS testing and treatment, pregnancy testing, prenatal care, birth control, and family planning). This disclosure will be made both verbally and in writing.

I understand that if I do not sign this authorization, I will not be denied treatment; however, I will lose the benefit of my treatment provider knowing about the treatment information from the previous treatment provider.

I understand that my records are protected under federal regulations governing Confidentiality of Alcohol and Other Drug Abuse Patient Records, 42 C.F.R. Part 2, the Health Insurance Portability and Accountability Act (HIPPA), 45 C.F.R. pts. 160 &164, and Wis. Adm. Code section HFS 92.05 and 92.06, and cannot be disclosed without my written consent. I may inspect and receive a copy of any material that is disclosed if I request it. I may revoke this consent at any time with WRITTEN NOTIFICATION, except to the extent that action has been taken in reliance on it.

This authorization for disclosure of information is effective until revoked in Writing

_____
Signature of Patient or Legal Guardian Date

_____
Print Name of Patient or Legal Guardian

Patient Registration Paperwork

Great Mines
HEALTH CENTER

Dental Paperwork:

Dental Health History Form

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	
Do you drink alcohol?	Yes No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other?	Yes No	If yes
Do you use controlled substances?	Yes No	If yes

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

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

Have you ever had any serious illness not listed above?	Yes No	If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

Great Mines Health Center

School Based Setting **DENTAL** Treatment Consent

Childs name: _____ Childs Birthdate: _____

Guardians name: _____

PERMISSION FOR OPERATIVE AND/OR DIAGNOSTIC PROCEDURE AND/OR TREATMENT

1. I hereby understand and authorize Great Mines Health Center providing dentist and/or assistants of their choice to perform upon my child/the patient named above, the following operation(s) and/or procedure(s) as deemed necessary by the treating dentist: Comprehensive dental care, not limited to, dental examination, x-rays, dental sealants, dental restorations (such as composite fillings, silver fillings, stainless steel crowns, pulpal therapies (treat the nerve inside the tooth), extraction of primary or baby teeth, orthodontic appliances, tooth cleaning and fluoride treatments. Only when necessary, the child's hands and head may be held still to limit disruptive movements to keep the child from injuring themselves or others while treatment is being completed. I understand that there are risks to dental treatment and when dental anesthetics are used including swelling, pain, allergic reaction, etc… If I would like further information about risks associated with dental treatment, please call (573)-438-8401 to speak with the dental staff or dentist.

2. If my child has high anxiety or is uncooperative and would require the use of nitrous oxide, sedation to receive dental treatment, or has other needs that cannot be met in the school dental clinic, I will need to schedule to be seen in the main dental clinic.

3. GMHC staff have fully explained to me the nature and purpose of the anticipated or planned treatment and has also informed me of expected benefits and complications (from known and unknown causes), advantages and disadvantages, attended discomforts and risks that may arise as well as possible alternatives to the proposed treatment, including no treatment. I have been given the opportunity to ask questions, and all my questions have been answered fully and satisfactorily. I acknowledge that no guarantees or assurances have been made to me concerning the results of treatment.

4. I authorize Great Mines Health Center to use photographs, radiographs, treatment records, and other diagnostic materials for the purpose of teaching, research, and scientific publications with the assurance that my child's identity will remain confidential. If I decline consent to the use of records and photographs initial on this line; otherwise leave blank: _____

A dentist from Great Mines Health Center (GMHC) will be evaluating my child's dental condition. If my child requires treatment on multiple teeth, GMHC will do its best treat as many teeth in one appointment as possible. GMHC hopes to minimize your child's time away from class. However, it may take multiple appointments to treat multiple diseased teeth. In the process of dental treatment, if my child develops pain or oral infection I will contact GMHC's office at (573)-438-8401 for an appointment in the main office at #1 Southtowne Drive, Potosi, MO 63664.
Local anesthetics are administered for most dental treatment. After treatment my child may experience pain and swelling. There is a possibility that my child may bite the inside of his or her mouth or tongue before anesthesia wears off. My child will be instructed not to do so by GMHC staff.

I, _____ (guardians name) understand that I can be present at the school if I so choose while my child is receiving dental treatment. If I am not present I leave treatment decisions up to the dentist's professional judgment and experience. The dentist may change the treatment plan if it is deemed in his or her professional judgment to be in the best interest of my child. This signed consent authorizes treatment for my child's initial and future dental appointments. I understand that I am free to withdraw my consent to treat at any time in writing and that this consent will remain in effect until I choose to terminate it.

Parent or Guardian's Name (please print): _____

Your relationship to the child: _____

Parent or Guardians Signature: _____ Date: _____

Witness: _____ Date: _____

Great Mines Health Center

Caries Risk Assessment Form (Age >6)

Patient Name:	
Birthdate:	Date:
Age:	Initials:

The following questions were developed by the American Dental Association to help evaluate the risk that your child has for the development of tooth decay. Accurate answers will help us provide the proper dental treatment for your child.

Contributing conditions to caries development or prevention (Parent section) **Please circle the answers that best applies to your child**				
I.	**Fluoride Exposure** (through drinking water, supplements, professional applications, toothpaste)	YES	NO	
II.	**Sugary Foods or Drinks** (including juice, carbonated soft drinks, energy drinks, etc…)	Primarily at mealtimes		Frequent or prolonged exposure between meals
How many times a day does your child have snacks or sugary drinks between meals? 1, 2, 3, more than 3 times a day				
III.	**Caries or cavity Experience of Mother, Caregiver and/or other Siblings**	No cavities in the last 24 months	Cavities in the last 7 to 23 months	Cavities in the last 6 months
IV.	**Dental Home:** regularly sees a dentist for treatment	YES	NO	
V.	**Special Health Care Needs** (developmental, physical, medical or mental disabilities that prevent or limit performance of adequate oral health care by themselves or caregivers)	NO		YES
VI.	**Chemo / Radiation Therapy**	NO		YES
VII.	**Eating Disorders**	NO	YES	
VIII.	**Drug / Alcohol abuse**	NO	YES	

Office use only below this line

Clinical Conditions (Circle all that apply)				
I.	Visual or radiographic evidence of restorations, cavitated or non-cavitated carious lesions	No new caries or restorations within 36 months	1 or 2 new carious lesions or restorations in the last 36 months	3 or more carious lesions or restorations in the last 36 months
II.	Missing teeth due to caries in the past 36 months	No		Yes
III.	Visible plaque	No	Yes	
IV.	Dental / Orthodontic Appliances present	No	Yes	
	Unusual tooth morphology that compromises oral hygiene	No	Yes	
	Interproximal restorations – 1 or more	No	Yes	
	Exposed root surfaces present	No	Yes	
	Restorations with overhands and or open margins; open contacts with food impaction	No	Yes	
	Xerostomia	No		Yes

Overall assessment of dental caries risk: **Low** **Moderate** **High**