

## Treatment Policy

- I understand that I may receive services at Marian Clinic Dental only if I do not have any type of private dental insurance. I understand that government insurance, Medicaid, is accepted.
- I understand that a licensed dentist, who is either employed or volunteering, and a dental assistant see all patients. Marian Clinic Dental may enter into agreements with dental schools to place dental students at the clinic. I understand that I may be treated by a dental student who is directly supervised by a licensed dentist. A dental hygienist might also see me. I give permission for evaluations and treatment for myself, or the minor child named here, by these dental personnel.
- I understand that I must provide complete and accurate information when completing application forms, including proof of income. Patients must update registration and proof of income annually.
- I understand that it is my responsibility to notify Marian Clinic Dental of any changes in phone number, address, or income.
- I agree to pay the Clinic for services received at a reduced fee determined from information compiled from application.
- I understand that I need to give 24 hours notice in advance to cancel an appointment and that if I do not notify the clinic of cancellation, it will be a failed appointment. I also understand that the Dental Clinic will no longer schedule appointments after two missed appointments, and I will need to sit and wait for an available opening.
- I understand that if I, or the minor named here, do not arrive within 10 minutes of the scheduled appointment time, another appointment will have to be made and this will be counted as a failed appointment.
- I understand that an adult must accompany children under 18 years of age. A family member is only allowed in treatment room with the approval of dental staff. I understand that children in the patient waiting room must be attended to at all times while waiting for patient to complete treatment.
- I understand that Clinic staff can dismiss me or a minor child for any of the following reasons:

Threatening, abusive or disruptive behavior while at the Clinic

Not following the advice given by a dentist for the benefit of my health.

Failure to follow through with a referral from Marian Clinic Dental, to a specialist.

- I understand that “dismissal” means denial of future services at the Clinic.
- I understand that the Clinic is not responsible for any bills incurred outside of the services it provides me, such as referrals, an emergency room visit, medications or supplies.
- I understand that all files are kept confidential by Clinic staff and that my written consent is required for any release of information by the Clinic to other persons or agencies, except as required by law in cases of court orders, child abuse or life threatening situations. The staff is required by law to report any suspicion of child or adult abuse, including neglect or emotional, physical or sexual abuse.
- I have read the statements above, and I understand them or someone has clarified to me anything I did not understand. I agree to the terms stated here and I willingly provide information about myself in order to receive care.

Patient or guardian signature \_\_\_\_\_ Date \_\_\_\_\_

# Marian Clinic Dental Registration

**Patient last name** \_\_\_\_\_ **First name** \_\_\_\_\_ **Middle initial** \_\_\_\_\_

Male \_\_\_ Female \_\_\_ Date of Birth \_\_\_\_\_ SSN# \_\_\_\_\_

Street address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ County \_\_\_\_\_

Home phone \_\_\_\_\_ 2<sup>nd</sup> contact phone \_\_\_\_\_

Employer \_\_\_\_\_

If patient is child, name of parent or legal guardian \_\_\_\_\_ Relationship \_\_\_\_\_

Is patient: Caucasian \_\_\_ Hispanic \_\_\_ African-American \_\_\_ Asian \_\_\_ Native American \_\_\_

If Native American, what tribe? \_\_\_\_\_ Copy of card \_\_\_yes \_\_\_no

Is patient: Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Separated \_\_\_ Minor \_\_\_

If married, name of spouse \_\_\_\_\_

**Why is patient seeking care here at the Marian Clinic Dental? (Check all that apply):**

- \_\_\_ Not eligible for Medicaid, MediKan or Veteran's benefits
- \_\_\_ No income at this time
- \_\_\_ Cannot afford dental insurance at this time
- \_\_\_ Employer does not offer dental insurance
- \_\_\_ Employer offers dental insurance but employee share is too expensive for me
- \_\_\_ Have medical insurance but no dental insurance

**List all members of your household, including patient:**

Name	Age	Relationship to Patient	Place of Employment
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**List ALL sources of GROSS MONTHLY household income (before taxes) Amount**

a) Employment (include tips)	_____
b) Employment (include tips)	_____
c) Unemployment compensation	_____
d) Worker's compensation	_____
e) Temporary aid to needy families (TANF)	_____
f) Child support	_____
g) Alimony	_____
h) Pension	_____
i) Social security	_____
j) SRS income (Welfare)	_____
k) Support from friends, other family members, etc.	_____
l) Housing from friends, family or shelter	_____
m) Utilities paid by friends, family, other	_____
n) Other _____	_____
<b>Total</b>	_____

This information is complete and correct and I provide it in order to receive care under the Charitable Health Care Provider program (K>S>A> 75-6120).

**If the Clinic finds that you have intentionally given false financial information, you will be denied services.**

**Patient signature (or legal guardian)** \_\_\_\_\_ **Date** \_\_\_\_\_

## Health History

Name of Patient \_\_\_\_\_

Is patient under the care of a physician?  Yes  No

Name of patient's physician or clinic \_\_\_\_\_

If under a doctor's care, for what condition? \_\_\_\_\_

Is patient taking medication at this time?  Yes  No

If so, please list here: \_\_\_\_\_

### **Medical** Does the patient have or has he/she ever had any of the following? (Check all that apply)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Heart problems (If so, please explain) _____ |   |   |
| <input type="checkbox"/> Congenital heart problem                     | <input type="checkbox"/> Heart murmur                 | <input type="checkbox"/> Circulatory problems               |
| <input type="checkbox"/> High blood pressure                          | <input type="checkbox"/> Low blood pressure           | <input type="checkbox"/> Epilepsy                           |
| <input type="checkbox"/> Diabetes                                     | <input type="checkbox"/> Sickle cell anemia           | <input type="checkbox"/> Asthma                             |
| <input type="checkbox"/> Blood disorder or disease                    | <input type="checkbox"/> Artificial joint replacement | <input type="checkbox"/> Lung disease                       |
| <input type="checkbox"/> Hemophilia                                   | <input type="checkbox"/> Rheumatic fever              | <input type="checkbox"/> Tuberculosis                       |
| <input type="checkbox"/> Venereal disease                             | <input type="checkbox"/> HIV/AIDS                     | <input type="checkbox"/> Allergic reactions                 |
| <input type="checkbox"/> Shortness of breath                          | <input type="checkbox"/> Stroke                       | <input type="checkbox"/> Sinus problems                     |
| <input type="checkbox"/> Allergic reaction to metals or jewelry       |   | <input type="checkbox"/> Hepatitis (If so, what type) _____ |
|   |   | <input type="checkbox"/> Cancer (If so, what type) _____    |

Please list any drug allergies patient has: \_\_\_\_\_

Does the patient use:  Tobacco?  Caffeine  Alcohol  Smokeless tobacco?

If so, please explain how much and how often: \_\_\_\_\_

(Women only) Is patient pregnant?  Yes  No

### **Dental** What is patient's reason for making this dental appointment?

Need routine examination  Need emergency dental work

Describe the main problem patient is having: \_\_\_\_\_

Describe patient's current dental health:  Good  Fair  Poor

How often does patient brush his/her teeth?  Once a day  Twice a day  Every other day   
 Once a week  Never  Other \_\_\_\_\_

Has patient ever had any of the following? (Check all that apply)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Unusual reaction to anesthetic                       | <input type="checkbox"/> Bad breath                  | <input type="checkbox"/> Bleeding gums      |
| <input type="checkbox"/> Broken or decayed teeth                              | <input type="checkbox"/> Difficulty chewing          | <input type="checkbox"/> Missing teeth      |
| <input type="checkbox"/> Dissatisfaction with appearance of teeth             | <input type="checkbox"/> Grinding/clenching of teeth | <input type="checkbox"/> Frequent headaches |
| <input type="checkbox"/> Swelling or lumps in mouth                           |  |   |
| <input type="checkbox"/> Retainers or braces for orthodontic purposes         |  |   |
| <input type="checkbox"/> Tooth sensitivity to hot, cold, sweets or pressure   |  |   |
| <input type="checkbox"/> Unusual sounds in ear while chewing or opening mouth |  |   |
| <input type="checkbox"/> Sores on lips or in mouth that are slow to heal      |  |   |

Do you want to talk to the doctor about any problems not listed above?  Yes  No

Additional comments: \_\_\_\_\_

I give permission to staff of Marian Clinic Dental to administer such medication and anesthetics and to perform such diagnostic and therapeutic procedures necessary for my dental care. The information I have given here is correct to the best of my knowledge. I agree to notify the Clinic if there are changes in my medical or dental history.

**Patient or guardian signature** \_\_\_\_\_ **Date** \_\_\_\_\_

## **Acknowledgement of Receipt**

I hereby acknowledge that I have been offered and/or received a copy of Marian Clinic's Notice of Privacy Practices.

\_\_\_\_\_ Date \_\_\_\_\_  
Signature of patient or patient's representative

Printed name of patient/patient's representative: \_\_\_\_\_

Relationship to the patient: \_\_\_\_\_