Marian Dental
CLINIC | SCL Health

Patient last name_____ **First name**_____ **Middle initial**_____

Male_____ Female_____ Date of Birth_____ SSN#_____

Street address_____

City_____ State_____ Zip_____ County_____

Home phone _____ 2nd contact phone_____

Employer_____

If patient is child, name of parent or legal guardian_____

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 are you seeking care here at the Marian Dental Clinic? (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
- ☐ I have no dental insurance
- ☐ I have Medicaid/KanCare
- ☐ I have private insurance
- ☐ I was referred by a friend
- ☐ Employee, employee family, friend, and/or community member

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)

Patient signature (legal guardian)_____ **Date**_____

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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)

☐ Heart problems (If so, please explain)_____

☐ Congenital heart problem	☐ Heart murmur	☐ Circulatory problems
☐ High blood pressure	☐ Low blood pressure	☐ Epilepsy
☐ Diabetes	☐ Sickle cell anemia	☐ Asthma
☐ Blood disorder or disease	☐ Artificial joint replacement	☐ Lung disease
☐ Hemophilia	☐ Rheumatic fever	☐ Tuberculosis
☐ Venereal disease	☐ HIV/AIDS	☐ Allergic reaction
☐ Shortness of Breath	☐ Stroke	☐ Sinus problems
☐ Allergic reaction to metal or jewelry	☐ Hepatitis (if so, what type)_____	

☐ 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)

☐ Unusual reaction to anesthetic	☐ Bad breath	☐ Bleeding gums
☐ Broken or decayed teeth	☐ Difficulty chewing	☐ Missing teeth
☐ Dissatisfaction with appearance of teeth	☐ Grinding/clenching of teeth	☐ Frequent headaches
☐ Swelling or lumps in mouth	☐ Retainers or braces for orthodontic purposes	
☐ Tooth sensitivity to hot, cold, sweets or pressure		
☐ Unusual sounds in ear while chewing or opening mouth		
☐ 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 Dental Clinic to administer such medication and anesthetic 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**_____

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AUTHORIZATION
to Discuss Protected Health Information

Through the Health Insurance and Accountability Act (HIPAA), the Department of Health and Human Services established national standards for the privacy or protected health information (PHI). In compliance with these Federal regulations, Marian Dental Clinic may not discuss your medical/dental care with anyone without your express written permission, except in the case of emergency or as required by law. This does not apply to disclosing information to carry out treatment, payment or health care operations.

Please list the full names of people with whom you give Marian Dental Clinic authorization to discuss your care (i.e., medication refills, appointment scheduling, billing information, medical history, etc.) Examples include spouse, parent(s), child, sibling, significant other, friend(s), interpreter, etc.

If you choose not to name anyone, please indicate "NO ONE."

PLEASE NOTE: This does apply to minor-children (18 years of age or younger). We do need your permission to discuss your care with anyone – including your parent(s).

1. _____ _____
   Name Relationship

2. _____ _____
   Name Relationship

3. _____ _____
   Name Relationship

4. _____ _____
   Name Relationship

Signature_____ **Date**_____

3164 SE 6th Ave., Topeka, KS 66607 **P** 785-233-2800 **TF** 1-866-379-2306 **F** 785-233-5116 **mariandental.org**

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ACKNOWLEDGMENT OF RECEIPT

I hereby acknowledge that I have been offered and/or received a copy of Marian Dental 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:_____

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TREATMENT POLICY

- I understand that licensed dentists and dental hygienists, who are either employed or volunteering, see all patients. Marian Dental Clinic may enter into agreements with dental schools to place students in the clinic; I consent to be treated by a student who is directly supervised by a licensed professional. 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 household income. Patients must update information and proof of income annually.
- I understand that it is my responsibility to notify Marian Dental Clinic of any changes in phone number, address and income.
- I understand that if proof of income is not provided I will be responsible for payment of services at the highest clinic fee rate.
- I agree to pay the clinic for services received at a reduced fee determined by my household income. If I do not have dental insurance or my dental insurance denies services or they are not covered under my benefit plan, I agree to pay the clinic at the reduced fee rate.
- I hereby authorize my dental insurance benefits to be paid directly to the Marian Dental Clinic. I authorize the release of pertinent medical and dental information to all designated insurance carrier(s).
- Il understand that I need to give 24 hours notice in advance to cancel an appointment. I also understand that if I do not notify the clinic of cancellation, it will be a failed appointment. I understand that the Marian Dental Clinic will no longer pre-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, arrive 10 minutes late to a scheduled appointment time, my appointment may need rescheduled.
- 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 to specialist, as advised by Marian Dental Clinic.
  - Miss two appointments and not call in to cancel.
- I understand that "dismissal" means denial of future services at the clinic and an alternative contact for a dental provider will be given to me.
- I understand that the clinic is not responsible for any bills incurred outside of the services it provides me, such as referral, 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 case 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 the best possible care.

Patient or guardian signature_____ **Date**_____

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HEALTHCARE FINANCIAL ASSISTANCE APPLICATION

Patient name_____ **Account #**_____

Date of Birth_____

Address_____

City_____ State_____ Zip_____ County_____

Home phone _____ Cell phone_____ Work phone_____

Email_____

☐ Single ☐ Married/Significant other ☐ Divorced/Separated ☐ Widow/Widower

Responsible party name_____ Relationship_____

Date of Birth_____

Address_____

Home phone _____ Cell phone_____ Work phone_____

Spouse name _____ Date of Birth_____

Address_____

Home phone _____ Cell phone_____ Work phone_____

List dependents living with you for whom you are responsible. Please include name(s), age(s) and DOB:

_____ _____

_____ _____

_____ _____

_____ _____

My signature attests that the information I have provided on this form is accurate and true to the best of my knowledge. I understand that SCL Health requires verification of income before any determination is made. I also understand that my credit may be accessed, at no expense to me, to verify the above information.

Patient signature (legal guardian)_____ **Date**_____

FOR OFFICE USE ONLY

☐ Completed, signed and dated application

☐ At least one of the following, documenting income for the last 3 months OR last year's tax return:
- Copy of pay stubs for patient, spouse and/or significant other
- Copy of award letter(s) – Unemployment, Social Security, etc., displaying monthly benefit
- Copy of bank statements

☐ Copy of valid photo ID: Driver's License, Passport, Visa, etc.

Family Size_____ Income_____ Poverty Level %_____ Sliding Scale Level_____

Special notes:_____

Office associate name:_____ APPROVE DENIED Date:_____