Family Health Centers
OF SOUTHWEST FLORIDA, INC.

TODAY'S DATE

PATIENT REGISTRATION FORM - DENTAL

Social Security No.:	First Name:	Middle:	Last:

Sex:	Gender Identity:	Sexual Orientation:
□ Male □ Female	□ Male □ Female □ Other □ Decline to Answer □ Transgender Male (Female-to-Male) □ Transgender Female (Male-to-Female) □ Genderqueer (Neither exclusively Male nor Female)	□ Straight □ Gay □ Lesbian □ Bisexual □ Other □ Unknown □ Decline to Answer

Birth Date:	Marital Status: □ Single □ Married □ Divorced □ Widowed □ Legally Separated

Race: □ Asian □ Black/African American □ White □ American Ind./Alaska Nat. □ Native Hawaiian □ Pacific Islander □ Haitian Black □ Haitian White □ More Than One Race	Ethnicity: □ Hispanic or Latino □ Non-Hispanic	Preferred Language:
	Employed: □ Yes □ No	Employer:
Street Address:		Home Phone:
City: State: ZIP Code:		Cell Phone:

Email:	Work Phone:	Preferred Method of Contact:

Referral Source: □ Referring Provider □ Walk-In □ Yellow Pages □ Family/Friend □ Ins. Company □ Hospital □ Newspaper □ Other/Unknown □ Flyer/Mailing □ School □ Health Fair □ Outreach Event

INSURANCE INFORMATION
(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Ins. Carrier:	Pt's Relationship to Subscriber:	Group No.:	Policy No.:

EMERGENCY CONTACT INFORMATION

□ Parent □ Spouse □ Child □ Other Sex: □ M □ F

First Name:	Middle:	Last:

Preferred Language:	Home Phone:	Cell Phone:	Work Phone:

PARENT / GUARDIAN INFORMATION

□ Parent □ Spouse □ Child □ Other Sex: □ M □ F

First Name:	Middle:	Last:

Social Security No.:	Birth Date:	Preferred Language:	Home Phone:	Cell Phone:	Work Phone:

PREFERRED PHARMACY

Pharmacy Name:	Phone:	Fax:

Street Address or Cross Street:	City:	State:	Zip Code:

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GENERAL CONSENT FOR TREATMENT AND BILLING

I, the undersigned, give permission for myself or minor child, as indicated above, to undergo all necessary tests, examinations, treatments, or other procedures required by the medical or dental staff for Family Health Centers of Southwest Florida, Inc. (FHCSWF) to diagnose and/or treat illness(es).

I realize that the practice of medicine, surgery, and dentistry is not an exact science, and I acknowledge that no guarantees have been made to me as a result of treatments or examinations by FHCSWF.

I consent to the release of my medical and dental information by FHCSWF and/or authorized institutions or agencies accepting the patient for medical, dental, or institutional care. I consent to the release of medical and dental information to patient's insurer. I give permission to release data (medical, dental, and personal) to such government agencies as is required of FHCSWF.

I hereby authorize payment to FHCSWF of benefits due to me in my pending claim and/or MAJOR MEDICAL BENEFITS otherwise payable to me, but not to exceed the health center and/or physician's or dentist's regular charges for this period of treatment.

Family Health Centers is affiliated with various educational facilities. I understand I will be notified by these personnel that they are a student and have the right to refuse to have them involved in my care. I also understand that if they are involved in my care, an employed healthcare professional of Family Health Centers is overseeing all services and care provided.

FHCSWF PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

I acknowledge that a copy of the FHCSWF Patient Bill of Rights and Responsibilities, a mutual agreement between me and FHCSWF, has been made available to me. A printed copy is available upon request.

HIPAA – NOTICE OF FHCSWF PRIVACY PRACTICE

I acknowledge that a copy of the Statement of Patient Privacy Practices, which explains the commitment of FHCSWF to protecting my personal health information in compliance with the law, has been made available to me. A printed copy is available upon request. I do hereby authorize the unrestricted release of my personal health information to the following individuals:

NAME:	RELATIONSHIP (e.g. – Mother, Sister, Spouse, etc.)
1.	
2.	
3.	

ADVANCE DIRECTIVES – RIGHT TO DECIDE – END OF LIFE DECISIONS

You cannot remove all uncertainty about your future healthcare needs but, by having Advanced Directive, you can have the peace of mind that comes from making your wishes known in advance. Please make a copy of any Advanced Directives and FHCSWF will place in your Medical Record.

Do you have a Living Will?	☐ Yes	☐ No
Do you have a Health Care Surrogate?	☐ Yes	☐ No
Do you have a Durable Power of Attorney?	☐ Yes	☐ No

Signature of Patient/Responsible Party/Guarantor:_____ **Date:**_____

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Patient Dental History

Reason for today's visit:

Date of last medical visit:

Have you had any serious illnesses or operations including head, neck or jaw injuries? ☐ YES ☐ NO

If yes, please describe:

Do you have a history of fainting? ☐ YES ☐ NO If yes, what was the cause:

Are you taking, or have you recently taken any prescription or over the counter medicine(s)? ☐ YES ☐ NO

If so, please list all:

Has your medical doctor ever told you to take medication for a heart murmur prior to any Dental Treatment? ☐ YES ☐ NO

If yes, please list:

Do you have any allergies to medications or latex based products? ☐ YES ☐ NO

If yes, please list:

Do you smoke or use any tobacco products? ☐ YES ☐ NO

Have you ever had abnormal or prolonged bleeding after a dental extraction? ☐ YES ☐ NO

Do you have any slow healing wounds? ☐ YES ☐ NO

Are you pregnant? ☐ YES ☐ NO Due date: Nursing? ☐ YES ☐ NO

Have you ever had a blood transfusion? ☐ YES ☐ NO If Yes, what year?

Are you HIV positive? ☐ YES ☐ NO Do you have AIDS? ☐ YES ☐ NO CD4+ Count:

Have you ever been diagnosed with any of the following: **Check all that apply**

Autoimmune Disease	☐	Heart Attack/Stroke	☐	Rheumatic Fever	☐
Blood Disease	☐	Muscular Disease	☐	Kidney Disease	☐
Diabetes	☐	Psychiatric/Behavioral Problems	☐	Liver Disease	☐
Developmental Delay	☐	Respiratory Disease	☐	Tumor/Growth	☐
Heart Disease	☐	Rheumatism Arthritis/Osteoarthritis	☐	Venereal Disease	☐
Heart Murmur	☐	Skin Disease (Eczema, Rosacea)	☐	Jaundice or Hepatitis	☐
High Blood Pressure	☐	Stomach Intestinal Disease	☐	Other:	

Do you have a history of, or, currently being treated for any of the following: **Check all that apply**

Artificial Heart Valves	☐	Previous infective endocarditic diagnosis	☐
Transplant	☐	Congenital Heart Disease	☐
Joint replacement	☐	Pacemaker	☐

If checked, please explain:

Have you ever been or are currently being treated for cancer with chemotherapy or radiation? **(circle one or both)**

If yes to chemotherapy: When was your last cycle? When is your next cycle?

Do you currently have a port (Infusaport/Hickman Venous)?

If yes to radiation: When was the last therapy given?

If you are scheduled for therapy, when will you start?

Patient/Guardian Signature: _____ Date: _____

Dentist Signature: _____ Date: _____