Hope Center
10274-A Hwy 104
Fairhope, Al. 36532

Today's Date: ________________

Name: ______________________________________
First MI Last

Address: ________________ City__________ State & Zip__________ Email:__________

Home# (___)__________ Cell# (___)__________ **Pharmacy Name-Location and #**__________

____

Date of Birth: __________ **Sex:** ❑ Male ❑ Female **Social Security Number:** __________

Race/Ethnicity: ❑African American ❑White ❑Native American ❑Asian ❑Latino/Latina ❑Other (specify):__________

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other (specify):__________

Employment Status: ❑ Employed ❑ Unemployed **Number of hours worked each week:**______

Employer's Name:__________________ **Employer Phone #** __________

Health Insurance: ❑ None ❑ Medicaid ❑ Medicare ❑ Other __________

Please Provide 2 Emergency Contacts

Next of Kin/Emergency Contact:______________ **Phone:**(___)__________ **Relationship:** ________

Emergency Contact:______________ **Phone:**(___)__________ **Relationship:** ________

Church Affiliation:______________________________________

Referred by: ❑Physician ❑Dentist ❑Friend/Family ❑Hospital ❑Media ❑Yellow Pages
❑Church__________ ❑Other (specify):__________

Primary Care Physician: __________________ **Physician Phone:** (___)__________

Have you been to the Emergency Room in the last 12 months? ❑Yes ❑No
If yes, which hospital __________________ Month/Year __________/__________

COMPLETE IF PATIENT IS A CHILD UNDER 18:

Name of Responsible Party: ______________________________

Social Security Number: ______________ **Date of Birth:** __________

❑**Same as Above** or **Street Address:** ________________ **City:** __________ **Zip:** ________

Home Phone: __________ **Work Phone:** __________ **Other Phone:** __________

The above information is true to the best of my knowledge. I understand that I am financially responsible for the balance of any office visits. By signing below I am stating I have no insurance of any kind. I also authorize Hope Center, Inc. to release or obtain any information required to establish my status as a client/patient.

Signature:______________________________ **Date:**__________

Signature of Parent/Guardian: ______________________ **Date:**__________

Hope Center Witness:______________________________ **Date:**__________

MEDICAL HISTORY

PATIENT NAME ______________________________ Birth Date ______________________________

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, please explain: ____________
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ____________
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ____________
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ____________
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ____________
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No ____________
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: ____________

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

Condition		Condition		Condition		Condition	
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 Problem	◯ 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 ____________

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 ______________________________ DATE ____________

HOPE CENTER

I, ___________________________, consent to be a patient at the above named office and agree to a radiographic and clinical examination. **I also understand and consent to the following:**

1. During the course of treatment, I may undergo procedures in the phases of dentistry that includes fillings, extractions, cleanings and local anesthesia.

2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4. I understand there are risks involved with any dental and anesthetic procedure. These include, but are not limited to: Post-operative infection, swelling, bruising, pain, damage to adjacent teeth, tooth sensitivity, drug reactions and side effects, bleeding, damage to nerves or sinuses, temporary rapid heart beat, hematomas or severe allergic and possible life threatening reactions necessitating emergency care.

5. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

7. I understand the recommended treatment, the fee(s) involved, the risks of such treatment, any alternatives and risks of these alternatives, including the consequences of doing nothing. I have had all my questions answered and have not been offered any guarantees.

______________________________________ ______________

Patient or Guardian Date

______________________________________ ______________

Witness Date

PATIENT AGREEMENT&CONTRACT/CONSENT FOR TREATMENT/EMERGENCY NOTICE

To better serve you, we ask for your cooperation in following the policies listed below. If you are unable to follow these guidelines, or find them unacceptable, another health care provider may be better able to meet your needs.

I UNDERSTAND AND AGREE TO THE FOLLOWING:

1. I will inform Hope Center of any and all medical, dental and counseling providers I am currently seeing while a patient at the Hope Center. ________
2. I will inform Hope Center of all current medications at each visit. ________
3. I will inform Hope Center within 30days, if my insurance status, address, telephone number(s), or income changes. ________
4. I understand if I miss three appointments without notifying Hope Center, I may no longer be able to receive services. ________
5. I do hereby authorize the administrative staff of Hope Center to disclose any personal health information to other health care professionals, when medically necessary and to disclose my registration and screening information for purposes of obtaining health care at another facility. ________
6. I understand outside of the Hope Center any referral or other provider's fee is between the patient and that provider. Hope Center is not responsible. ________
7. I am solely responsible for following through on testing and treatment ordered by providers at the Hope Center. I understand that if I fail to follow the physician's or dentist orders my treatment may be unsuccessful. ________
8. I understand that if I am uncooperative, verbally or physically abusive, intoxicated or behaving in an inappropriate manner, I will not be eligible for services at Hope Center and will be discharged as a patient. ________
9. I understand that the Hope Center is a nonprofit organization/clinic/agency therefore; I will not seek legal action or recourse towards any volunteer(s) or staff associated with the Hope Center serving in a professional capacity or otherwise. ________
10. I give consent for ________________________________, to be seen at Hope Center; whether it be for medical, dental or counseling for evaluation and treatment.
    Signature:____ Date: ______________

11. RECORD OF HIPAA NOTIFICATION: I have read the Notice of Privacy Policy and Practices of the Hope Center.
    Signature: ____ Date: ________________
    *If you would like a copy of the Privacy Policy and Practices please notify the receptionist.

12. EMERGENCIES: **HOPE CENTER MEDICAL, DENTAL AND COUNSELING IS NOT AN EMERGENCY FACILITY.** I understand the Hope Center Medical, Dental and Counseling Clinic is staffed by professional doctors, dentist and counselors who volunteer their time. After business hours, Hope Center phones are answered by a voice-mail system and messages are not retrieved until the next business day. Due to this fact, *the Hope Center has limited operating hours and does not provide after hours services.* In the event of an emergency, call 911 or proceed to the nearest hospital emergency room.
    Signature: ____ Date: ________________

13. CONTRACT BETWEEN PATIENT, DENTIST, PHYSICIAN, COUNSELOR AND HOPE CENTER.
    Hope Center Medical is not a pain clinic or a mental health clinic. Therefore, Hope Center Medical does not write narcotics and/or benzodiazepines.
    In the event a dentist needs to write for pain medication they will be limited to 16 tablets. We do not refill. If the dental patient feels the need for more pain medication they will be required to make an appointment and see the next available dentist for follow up.
    I, ____ have read and understand the above contract regarding the Hope Center policy and procedures of narcotics and benzodiazepines medications.
    Signature: ____ Date: ________________

I have received a full explanation of the Hope Center's services and I understand and agree to all of the above. I understand that I can be terminated/discharged from the Hope Center if I have given wrong or misleading information or if I failed to follow the policies above.

Signature: ____ Date: ________________
Hope Center Witness: ______________________________ Date: ________________