

Today's Date: \_\_\_\_\_

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

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
                    First                                    MI                                    Last  
  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: \_\_\_\_\_

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

# Personal History

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason for today's visit \_\_\_\_\_

List any medical or dental problems you may have (i.e. diabetes, cancer, heart or breathing problems, etc.)  
\_\_\_\_\_  
\_\_\_\_\_

Current Medications: (please list) \_\_\_\_\_

Medication Allergies: \_\_\_\_\_ Food Allergies: \_\_\_\_\_

Circle any surgery you have had: Appendectomy Gallbladder Hernia Repair Heart Surgery  
Hysterectomy Tonsillectomy Other \_\_\_\_\_

Do you smoke? Yes No How many packs per day? \_\_\_\_\_

Do you drink alcohol? Yes No How much and how often? \_\_\_\_\_

Check any of the conditions below that you have or have had in your family health history. Please note in "self" column or note family relationship (father, mother, grandfather, grandmother, brother, sister, etc.)

Self	Family	Self	Family
<input type="checkbox"/> Allergies/Hay Fever	<input type="checkbox"/> _____	<input type="checkbox"/> Headaches	<input type="checkbox"/> _____
<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> _____	<input type="checkbox"/> Seizures	<input type="checkbox"/> _____
<input type="checkbox"/> Asthma	<input type="checkbox"/> _____	<input type="checkbox"/> Stroke	<input type="checkbox"/> _____
<input type="checkbox"/> Emphysema	<input type="checkbox"/> _____	<input type="checkbox"/> Indigestion	<input type="checkbox"/> _____
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> _____	<input type="checkbox"/> Ulcers	<input type="checkbox"/> _____
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> _____	<input type="checkbox"/> Bowel Problems	<input type="checkbox"/> _____
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> _____	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> _____
<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> _____	<input type="checkbox"/> Kidney Failure	<input type="checkbox"/> _____
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> _____	<input type="checkbox"/> Kidney Infection	<input type="checkbox"/> _____
<input type="checkbox"/> Arthritis	<input type="checkbox"/> _____	<input type="checkbox"/> Diabetes	<input type="checkbox"/> _____
<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> _____	<input type="checkbox"/> Cancer	<input type="checkbox"/> _____
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> _____	<input type="checkbox"/> Anemia	<input type="checkbox"/> _____

\_\_\_\_\_  
Nurse Signature

**This is a contract between Patient, Dentist, Physician and HOPE Center.**

HOPE Center Policy and Procedure regarding Narcotics and Benzo's, effective March 13, 2013.

This includes but is not limited to Lortab, Soma, Klonopin, Xanax, Lithium, Adderall.

Narcotics and Benzo's are temporary medications and not used or filled on a chronic basis at HOPE Center. HOPE Center is not a pain clinic or a mental health clinic. Therefore, all narcotics and benzo's will be written for one month at a time. If the patient is not able to wean off these drugs after the crisis period is over, the patient will be referred to a pain clinic or mental health clinic. HOPE Center is not responsible for the care of long term treatment of pain medications or psychotropic medications.

In the event of a patient, losing their medication or prescription, medication or prescription being stolen, self medicating, or in any way not follow the doctor's orders. The patient will not be given a refill and will be referred immediately to another doctor or facility.

I, \_\_\_\_\_ have read and understand the above contract regarding the HOPE Center policy and procedures of narcotic and benzo medications.

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

HOPE Center Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Comments:

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PATIENT AGREEMENT

Hope Center is a private (non-governmental), non profit agency which is designed to provide health care MEDICAL, DENTAL and COUNSELING to under-served families in Baldwin County and the surrounding areas.

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 if my address, telephone number(s), income within 30 days of any change.
2. I will give Hope Center 24 hours notice if I will be unable to keep my appointment.
3. If I miss three appointments without notifying Hope Center, I understand that I may no longer be able to receive services at the Center.
4. I understand that my charges per office visit are due at the time of service. I also understand that if I schedule a doctor's appointment and I am unable to pay my office fee, I will call Hope Center 24 hours prior to my appointment.
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.
6. I do hereby authorize the administrative staff of Hope Center to disclose my registration and screening information for purposes of obtaining health care at another facility.
7. I understand that only referral appointments made by Hope Center staff for me at other health care facilities will be at a discounted rate and/or free of charge. If I schedule an appointment or choose to see any other health care provider without approval from Hope Center, I will be responsible for the bill and I may lose my eligibility for obtaining health care at another facility.
8. I understand that I may choose to seek treatment, with any doctor of my choice, at any emergency room and that if I do so I will be responsible for the bill.
9. If I have any questions about an appointment or treatment, I will contact Hope Center. For each outside appointment I will present the forms that I have been given at Hope Center to the place of service.
10. I am solely responsible for following through on testing and treatment ordered by providers at the Center. I understand that if I fail to follow the physician's or dentist orders my treatment may be unsuccessful.
11. 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.
12. I understand that the Hope Center is a nonprofit organization/clinic therefore; I will not seek legal action or recourse toward any volunteer(s) associated with the Hope Center serving in a professional capacity or otherwise.

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

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_  
Interviewer's Signature \_\_\_\_\_ Date: \_\_\_\_\_



**CONSENT FOR TREATMENT**

I give consent for \_\_\_\_\_ to be seen at Hope Center; whether it be for medical, dental or counseling for evaluation and treatment. (If you are the patient, please sign for yourself).

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_

I \_\_\_\_\_ do hereby give Hope Center and parties designated by Hope Center, the right to use my image or photo in publications or promotional materials and displays.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**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.

**EMERGENCIES**

I understand the Hope Center Medical and Dental Clinic is staffed by professional doctors and dentists who volunteer their time. 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. After business hours, Hope Center phones are answered by a voice-mail system and messages are not retrieved until the next business day.

Signature \_\_\_\_\_ Date \_\_\_\_\_