DEMOGRAPHIC SHEET

DATE_____

NAME_____

FIRST MIDDLE INITIAL LAST

DATE OF BIRTH: (MM-DD-YYYY) _____

ADDRESS: STREET_____

CITY_____ STATE_____ ZIP_____

CELL PHONE_____ SECOND NUMBER_____

EMAIL_____

SOCIAL SECURITY NUMBER_____

SEX: MALE_____ FEMALE_____

RACE/ETHNICITY: AFRICAN AMERICAN_____ WHITE_____ NATIVE AMERICAN_____ ASIAN_____ LATINO/LATINA_____
OTHER (SPECIFY)_____

EMPLOYMENT STATUS: EMPLOYED_____ UNEMPLOYED_____

HEALTH INSURANCE: MEDICARE_____ MEDICAID_____ OTHER_____ NONE_____

PHARMACY NAME WITH LOCATION AND PHONE #_____

EMERGENCY CONTACT: NAME_____

EMERGENCY CONTACT: PHONE_____ RELATION: _____

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.I ALSO AUTHORIZE HOPE CENTER, INC. TO RELEASE OR OBTAIN ANY INFORMATION REQUIRED TO ESTABLISH MY STATUS AS A CLIENT/PATIENT. **BY SIGNING BELOW, I AM STATING THAT I HAVE NO INSURANCE OF ANY KIND.**

SIGNATURE_____ DATE_____

SIGNATURE OF GUARDIAN_____ DATE_____

HOPE CENTER WITNESS_____ DATE_____

MEDICATION SHEET

NAME: _____ **DOB:** _____ **CHART#** _____

ALLERGIES: _____

DATE	DRUG	STRENGTH	DOSE	ROUTE	FREQUENCY

08-11-2023 DLS

NAME:_____DOB:_____CHART#:_____

DATE	CHRONIC CONDITIONS

DATE	SURGERIES/ PREGNANCY HISTORY

FAMILY HISTORY

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: _____

lave 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?

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

PATIENT AGREEMENT CONTRACT, CONSENT FOR TREATMENT, EMERGENCY NOTICE

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 understand Hope Center is for the NON-INSURED OR UNDER INSURED ONLY! _____
2. 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. _____
3. I will inform Hope Center of all current medications at each visit. _____
4. I will inform Hope Center within 30 days, if my insurance status, (non-insured), address, telephone number(s) or income changes. _____
5. I understand if I miss three appointments without notifying Hope Center, I may no longer be able to receive services. _____
6. 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. _____
7. I understand outside of the Hope Center any referral or other provider's fee is between patient and that provider. Hope Center is not responsible. _____
8. I am solely responsible for the 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. _____
9. 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. _____
10. I give consent for _____, to be seen at Hope Center whether it be for medical, dental or counseling for evaluation and treatment.
11. Record of HIPAA Notification: I have read the Notice of Privacy policy and Practices of the Hope Center. _____ *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. After business hours, Hope Center phones are answered by a voice-mail system and messages are not retrieved until the next business day. I understand the Hope Center Medical, Dental and Counseling clinic is staffed by professional doctors, dentist 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 department. _____
13. Contract Between patient, dentist, physician and counselor and Hope Center. Hope Center is NOT a pain clinic or a mental health clinic. Therefore, Hope Center medical does not write for 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 pain medication prescriptions. 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.
14. **I understand 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.**

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 polices above.

Signature: _____ *Date:* _____

Witness: _____ *Title:* _____ *Date:* _____

Hope Center Dental Patient Agreement/Contract

I, _____, consent to be a patient of the Hope Center and agree to a radiographic and clinical examination.

I also understand and consent to the following:

1. Hope Center is NOT an emergency clinic.
2. During the course of treatment, I may undergo procedures in the phases of dentistry that includes fillings, extractions, cleanings, and local anesthesia.
3. I will provide a thorough and complete medical history, supply a full list of medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspects of my health history.
4. 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.
5. I understand there are risks involved with any dental and anesthetic procedure. These include, but are not limited to: Post-operative infections, swelling, bruising, pain, damage to adjacent teeth, tooth sensitivity, drug reactions and side effects, bleeding, damage to nerves or sinuses, temporary rapid heartbeat, hematomas or serve allergic and possible life threatening reactions necessitating emergency care.
6. My treatment plan may change at anytime and I will do my best to approach my dental care with optimism and open communication with me dentist, hygienist and dental office staff.
7. 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.
8. 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.
9. **I understand 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.**

I have read and fully understand and comply with the above agreement/contract. 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 polices above.

*Signature:*_____ *Date:*_____

*Witness:*_____ *Title:*_____ *Date:*_____