Dental Clinic Enrollment Information

To be eligible for New Heights Dental Clinic please check the boxes to confirm that they apply:

- ☐ I am not covered by any Health Insurance or Dental Insurance.
- ☐ I do not have and am not qualified for Medicaid (DSHS or Oregon Health Plan).
- ☐ I am not in active treatment with any Dental Practice in the greater Clark County area (unless specific arrangements have been made with that dentist).
- ☐ The income (of all people in my household) does not exceed the following limits:

Persons in Household	Annual Income	Monthly
1	$ 35,310	$ 2,943
2	$ 47,790	$ 3,983
3	$ 60,270	$ 5,023
4	$ 72,750	$ 6,063
5	$ 85,230	$ 7,103

Please check the boxes to confirm that you understand the following

- ☐ I will confirm my appointments by 12 Noon the day prior to my Scheduled Appointment
- ☐ I will let the Clinic know when I have obtained insurance coverage and no longer need assistance.
- ☐ I will keep the Clinic informed of any changes in my telephone number, address or other changes.
- ☐ If I have any serious ill effects from my dental care I will seek immediate assistance from Urgent Care or Emergency Facilities.

I have read and understand the above and I am eligible to be enrolled in the New Heights Dental Clinic.

_____ _____

Patient Signature Date

WELCOME!

Dental Health Questionnaire

New Heights DENTAL CLINIC

Medical Alerts
_____
_____
_____
_____
_____

Name_____

Address_____

_____

City State Zip

Phone_____ Birth date _____

Emergency Contact: Name_____

Phone_____

What is your immediate dental need?

_____

Tell me about your health

_____

Do you have a physician or other healthcare provider?_____

Have you been hospitalized or seriously ill in the past few years? No_____ Yes_____

For what? _____

Are you taking any medications? No_____ Yes_____ If yes, list all medications that you are taking:

Medication	Reason	How long?

Are you allergic to or react adversely to any drugs or medications? No_____ Yes_____

_____

Are you allergic to or react adversely to any metals, latex or dental materials? No_____Yes_____

Have you been advised to take antibiotics before dental treatment? No_____ Yes_____

Why?

_____

Religious Background_____

Is faith or religion or spirituality an important part of your life? No___ Yes___

How?_____

_____

Do you or have you had any of the following:

- ☐ Allergies
- ☐ Alzheimer's
- ☐ Anemia
- ☐ Anxiety Attacks
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Radiation Therapy
- ☐ Depression
- ☐ Diabetes
- ☐ Drug/Alcohol Abuse
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Glaucoma
- ☐ Headaches
- ☐ Abnormal Bleeding
- ☐ High Blood Pressure
- ☐ Heart Problems
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ Angina
- ☐ Heart Surgery
- ☐ HIV/AIDS
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Liver Disease/Hepatitis
- ☐ Osteoporosis

 Psychiatric Care Sexually Transmitted Disease Smoke/Tobacco Use Tuberculosis
 Stroke Ulcers

Women: Are you taking contraceptives or hormones? No_____ Yes_____

Are you pregnant? If so, expected delivery date. _____

Patient Signature_____ **Date**_____

Provider Signature_____ **Date**_____

Annual Provider Update (Sign name, & date)**:** _____

_____ _____

_____ _____

rwb 8/15

MESSAGE CONFIDENTIALITY

There are times when we need to communicate a report or message to you and cannot get in touch with you at your home. To contact you in a timely manner and maintain confidentiality, we ask the following:

If we are unable to reach you at your home phone number, may we contact you at work? YES___ NO___

Work phone #_____

May we contact you on your cell phone? YES___ NO___ Cell phone #_____

May we leave a message on your voice mail or answering machine? YES___ NO___

Other than yourself is there a family member or friend with whom you would allow us to discuss your dental information? YES___ NO___

_____

CONTACT NAME RELATIONSHIP TELEPHONE #

_____

PATIENT'S SIGNATURE PRINT NAME DATE