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Meeting Needs. Building Relationships. Living Faith.

DENTAL CLINIC

Opening the door for the good news of Jesus Christ through the practice of medicine and dentistry.

Personal

Last Name: _____ First Name: _____ Middle Name: _____

Today's Date: _____

Email address: _____ Check if prefer to be called ☐

Male ☐ Female ☒

Birthday: _____/_____/_____ Age: ___ SSN#: _____-____-_____

Home Address: _____

_____

Single ☒ Married ☒ Divorced ☒ Widowed ☒ Separated ☒

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Ext. _____

Employer:_____

Employer's Address: _____

How long have you been employed there? _____

Occupation: _____

What is the best time to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us? _____

Previous/Present Dentist: _____

Last visit date: _____ Reason for last visit: _____

Spouse/Emergency Contact Information

Emergency contact name: _____

Address: _____

Employer: _____

Work #: _____ Cell #: _____

Birthdate: _____/_____/_____

Relationship to you: _____

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DENTAL CLINIC

Insurance

Do you have dental insurance? _____
Insurance Co. Name: _____ Group #/ Policy #: _____
Insured's Name: _____ Relation: _____
Insured's Birthdate: ____/____/_____
Insured's Employer: _____
Employer's Address: _____
Do you have Medicaid?_____
Medicaid #: _____
Do you have Medicare? _____ Medicare #: _____

Medical History

Do you have a personal physician? _____
Physician's Name: _____
Phone #: _____ Last Visit: _____
Are you currently under the care of a physician? _____
Please Explain:
_____
How's your current physical health?
Good ☐ Fair ☐ Poor ☐
Do you smoke or use any form of tobacco? _____
How often do you consume alcohol?
Never ☐ Daily ☐ Weekly ☐ Monthly ☐
Have you had any metal rods, pins, or implants? _____
Are you taking any prescription medications? Yes ☐ No ☐
If so, please list _____
Are you taking any over the counter medications or herbal supplement drugs? _____
Do you use any recreational drugs? Yes ☐ No ☐
If so, please list _____ Frequency: _____
Have you ever taken Fosamax or any other bisphosphonates? _____
Any IV bisphosphonates? Yes ☐ No ☐ If so, when? _____
Have you ever taken Phen-Fen? _____
Are you currently pregnant? Yes ☐ No ☐ How many weeks? _____
Your due date? _____ Are you nursing? _____

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Have you ever had any of the following diseases or medical problems? (circle Yes or No)

Y N Abnormal Bleeding
Y N Alcohol/Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Joint, Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Colitis
Y N Congenital Heart Defect
Y N COVID-19
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N Hay Fever
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis
Y N Herpes/Fever Blisters
Y N High Blood Pressure
Y N HIV+/AIDS
Y N Hospitalized for Any Reason
Y N HPV (Human Papillomavirus)
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Lupus
Y N Mitral Valve Prolapse
Y N Osteoporosis (Paget's DZ)
Y N Pacemaker
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic/Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease/Trait
Y N Sinus Problems
Y N Smoking
Y N Stroke
Y N Thyroid Problems
Y N Tobacco Use
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Diseases

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Allergies

Do you have any of the following allergies?

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Latex
Y N Penicillin
Y N Tetracycline

Dental History

Why have you come to the dentist today? _____

Do you require antibiotics before dental treatment due to a medical condition? Yes ☐ No ☐

Are you currently in pain? Yes ☐ No ☐

Have you ever had a serious problem associated with any previous dental work? Yes ☐ No ☐

Are you fearful of the dentist? Yes ☐ No ☐

Have you ever had gum surgery? Yes ☐ No ☐

Do you have joint pain or have you been diagnosed with TMJ/TMD disorder? Yes ☐ No ☐

How would you rate your dental health?

Do you like your smile? Yes ☐ No ☐

Do your gums bleed? Yes ☐ No ☐

Do you floss? Yes ☐ No ☐ If yes, how often? _____

How many times a day do you brush? _____

Type of bristles on your toothbrush? Soft Medium Hard

How often do you replace your toothbrush? _____

Are your teeth sensitive to heat, cold, or biting? Yes ☐ No ☐

If so, please describe: _____

Have you lost any teeth? Yes ☐ No ☐

If yes, why? _____

Is there anything else you'd like to discuss with the dentist or anything we can pray for you about? _____

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For your partnership in your dental care at Mission First

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I also authorize the staff at Mission First to use any part of my medical/dental record or medical/dental information in order to obtain any necessary medical or dental consultations so that they may diagnose and/or treat my medical or dental needs comprehensively. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with this signed document serving as my informed consent.

_____ _____

Signature Date

I understand that I am responsible for payment of services rendered **on the day of my treatment**. Should I not pay my required fee, then I may be denied further treatment at this facility until my accrued debt is paid in full. If I am a new patient and I fail to attend my initial appointment or fail to give 24 hour notice of my inability to attend my first appointment, I forfeit the right to be seen at Mission First. Also, I acknowledge that if I fail to appear for my scheduled appointment three times that I become ineligible for future treatment at this facility. Should I need to reschedule my appointment, I commit to calling 24 hours in advance of my appointment time to do so. Also, I agree that if I am 15 minutes late or more for my scheduled appointment, then I will need to be rescheduled for another time.

_____ _____

Signature Date

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

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DENTAL CLINIC

Mission First Medical and Dental Clinic Financial Eligibility Determination Form

_____	_____	___/___/_____	_____
Last Name	First Name	Date of Birth	Sex

Section 1:

Do you have dental insurance? Yes ☐ No ☐ Do you have Medicare? Yes ☐ No ☐

Do you have medical insurance? Yes ☐ No ☐ Do you have Medicaid? Yes ☐ No ☐

Each patient's eligibility to pay an administration fee for services rendered will be determined by the patient's price code. Each price will represent an office visit fee based on the patient's household income and the number of members in the household.

Please circle the cost code which applies to you:

Cost Code	Annual Income	Office Visit Fee
A	$25,001-UP	$25
B	$20,001-25,000	$20
C	$15,001-20,000	$15
D	$10,001-15,000	$10
E (minimum)	$0-$10,000	$5

**Exceptions: the only dental procedures which will have an exception to the above price codes will be prosthetic dentistry and crown and bridge procedures in which supply cost will be required. The only medical procedure which will have an exception will be minor general surgeries that need to be sent off for lab and any special x-rays.

Note: All patient fees will go to the upkeep of the clinic and not to the volunteer health staff.

Section 11:

I certify by my signature that to the best of my knowledge, the above is a true and complete statement of my financial situation. I understand that the information I have given is subject to verification.

_____	_____	_____
Signature of patient or guardian	Signature of Mission First staff/volunteer	Date

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DENTAL CLINIC

AUTHORIZATION TO RELEASE/FAX MEDICAL RECORDS PROTECTION OF HEALTH INFORMATION

I authorize the use or disclosure of the medical records/protected health information(PHI) as described below. By authorizing the use or disclosure of the records described below, I authorize the custodian of the records to forward via facsimile; my records/protected health information, for review or inspection by the person(s) identified below:

_____ ___/____/_____-_____-_____

Patient's Name Date of Birth SSN

I authorize MISSION FIRST, INC. Medical/Dental Clinic to release and/or disclose my medical records/protected health information to:

Doctor: _____

The purpose of this request to release and/or disclose the medical records/PHI described above is for review by doctor listed above _____ or for _____.

__ I do not authorize the recipient to re-disclose the PHI described above without my prior written approval.

I understand that I have the right to revoke this authorization, in writing, at any time by notifying the requesting person. Such revocation will not affect actions taken by the requesting person prior to the date he/she received the written revocation.

I understand that my healthcare provider cannot condition medical treatment on whether I sign this authorization.

This authorization will expire upon my written revocation.

_____ _____ _____

Print Name Signature Date

If signed by patients authorized representative, describe the representative's authority:

__ Patient is a ward; I am patient's guardian, appointed by the _____ County Probate Court.
__ Patient is a ward; I am patient's guardian, appointed by the _____ County Juvenile Court.
__ Patient is a ward; I am patient's parent or natural guardian.
__ Patient is a deceased; I am the patient's surviving spouse or I am the patient's surviving spouse or I am the executor or administrator of the patient's estate, appointed by the _____ County Probate Court.
__ I am the patient's agent, empowered to make the foregoing request, as designated in the patient's general power of attorney.
__ I am the patient's agent, as designated in the patient's Durable Power of Attorney for Health Care.
__ Other _____

This Authorization to release protected information is designed to meet the requirements of a valid authorization as specified by the standards for privacy of individuality identifiable health information and (the HIPPA privacy rule), 45CFR, part 160 and 164. The prescribed content of a valid authorization is found at 45 CFR 164. 508.

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DENTAL CLINIC

MISSION FIRST LIABILITY AND MEDIA RELEASE FORM

I grant permission to Mission First, Inc. and its subordinates, to use my name and/or photographs for use in Mission First publications such as recruiting brochures, newsletter, and magazines, and to use my name and/or photographs on display boards, and to use my name and/or photographs in electronic versions of the same publications or on the Mission First, Inc. website or other electronic forms or media.

I hereby waive any right to inspect or approve the finished photographs or printed or electronic matter that may be used in conjunction with them now or in the future, whether that use is known to me or unknown, and I waive any right to royalties or other compensation arising from or related to the use of the photography.

I hereby agree to release, defend, and hold harmless Mission First, Inc. and subordinates, including any firm publishing and/or distributing the finished product in whole or in part, whether on paper or via electronic media, from and against any claims, damages or liability arising from or related to the use of the photographs without limitation.

I hereby agree that by participating in the activities of Mission First, Inc. that I will be fully responsible for any and all doctor, hospital and related medical expenses relating to any injuries or damages sustained while participating in the activity, travel or connecting therewith; waive and release Mission First, INc. from any claim of of any kind I may have relating to injuries or damages sustained while participating in the activity or travel in connection therewith; and indemnify and hold harmless Mission First, Inc. from any such claim that might be made.

Please check the paragraph below which is applicable to your present situation:
___ I am 18 years of age or older and I am competent to contract in my own name. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

___ I am the parent or legal guardian of the below name child. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

Date: _____
Name (Please Print): _____
Address:_____
(Street) (City) (State/Province) (Zip/Postal Code)
Date of Birth: _____
Phone number(s): _____
Signature of participant: _____
Signature of parent or legal guardian (if under 18 years of age): _____

This forma must be fully completed and returned to Mission First, Inc. prior to any participation with Mission First, Inc.

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DENTAL CLINIC

IMMUNITY FOR CHARITABLE AND VOLUNTARY MEDICAL SERVICES

According to MIssissippi Code Ann. Statue 73-25-38, any licensed physician or certified nurse practitioner who voluntarily provides needed medical or health services to any person without the exception of payment due to the inability person to pay for said services shall be immune from liability for any civil action arising out of the provision of such medical or health services provided in good faith on a charitable basis. Immunity under this section shall waiver in advance of the rendering of such medical services specifying that such services are provided without expectation of payment and that the licensed physician or certified nurse practitioner shall be immune as provided herein.

By signing this written waiver in advance of my medical service, I understand that the physicians, dentist, and practitioners are voluntarily providing medical service to me without any exemption of payment of payment or compensation for their services making them immune from liability for any civil action arising out of the provision of said services.

I understand that all fees collected by Mission First Medical and Dental Clinic will go to the upkeep of the clinic and supplies.

I understand that volunteer doctors, dentist, and practitioners will not receive any payment from patient's fee.

I also understand that by executing this written waiver, I agree to the above for the current visit and any following visits at the Mission First Medical and Dental Clinic.

Patient's Name (Print) _____

Patients Signature (Parent/Guardian if under 18 years of age) _____

Date _____
(A copy of this waiver will remain in the patient's medical record)

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