MarillacHealth
Committed to a healthier you.

New Patient Registration—Dental

Patient Registration

Today's Date _____

Patient Last Name _____ **First** _____ **Middle** _____

Mailing Address _____ **City** _____ **State** _____ **Zip** _____

Date of Birth _____ **Email Address** _____

Home Phone # _____ **Cell Phone #** _____

Primary care Doctor: _____**Preferred Pharmacy:** _____

****NOTE: WE ARE REQUIRED BY HRSA TO COLLECT THE FOLLOWING DATA****

Marital Status (Circle One) Divorced Domestic Partner Legally Separated Married

Significant Other Single Unknown Widowed Other

Sexual Orientation (Circle One) Straight/Heterosexual Bisexual Lesbian/Gay

Asexual Don't Know Unknown Choose not to disclose

Gender Identity (Circle One) Female Male Transgender Female Transgender Male

Other Two Spirit Choose not to disclose

Race (Circle One) Alaskan Native American Indian Black/African American Caucasian

Native Hawaiian Pacific Islander Asian Unknown Choose not to disclose

Ethnicity (Circle One) Hispanic or Latino/a Non-Hispanic or Latino/a Unknown Other

Family Size _____ ***Household Income $_____ (Annual) Employed ___Yes ___ No

***Please note – This does not replace our Sliding Fee Application for Sliding Fee Discount. If you would like to apply for our sliding fee discount, please inquire with one of our team members.

2333 N. 6th St. Grand Junction, CO 81501
2139 N. 12th St., Ste. 2 Grand Junction, CO 81501
510 29 ½ Rd. Grand Junction, CO 81504

Phone: 970-200-1600
Fax: 970-200-1612
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Household Status (Circle One) Homeless shelter Transitional Housing Doubling up

Streets, camp, bridges Private residence Other Choose not to disclose

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Seasonal or Migrant Worker (Circle One) Yes No

Employment Status (Circle One) Full Time Not Employed On Active Military Duty Child

Part Time Retired Seasonal Self-Employed Student Full Time Student Part Time

Emergency Contact

Name _____ **Phone #** _____ **Relation** _____

Parent/Guardian (If Applicable)

Last Name _____ **First** _____**Middle** _____

Home Phone # _____ **Cell Phone #** _____

Date of Birth _____ **Relation** _____**Additional Information** _____

Insurance Information

Primary Insurance _____**Subscriber's Name**_____ **Date of Birth**_____

Subscriber's ID _____ **Group #** _____ **Member ID #** _____

Relationship to Subscriber _____

Secondary Insurance _____**Subscriber's Name**_____ **Date of Birth**_____

Subscriber's ID _____ **Group #** _____ **Member ID #** _____

Relationship to Subscriber _____

Patient/Parent/Legal Guardian Signature _____ **Date** _____

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Date of Last Dental Visit _____

Have you EVER had any of the following? Please answer ALL questions.

AIDS/HIV+	Y	N	Drug Use	Y	N	High blood pressure	Y	N	Jaundice	Y	N
Alcohol use	Y	N	Eating Disorder	Y	N	Kidney Disease	Y	N	Stroke Date:	Y	N
Anemia	Y	N	Epilepsy	Y	N	Liver Disease	Y	N	Thyroid Disease	Y	N
Arthritis	Y	N	Excessive Bleeding	Y	N	Low Blood Pressure	Y	N	Sexually Transmitted Disease	Y	N
Artificial Joints_____ Date:	Y	N	Fainting	Y	N	Mental/Nervous disorder	Y	N	Tobacco Use (smoke/chew/vapor)	Y	N
Diabetes	Y	N	Hepatitis A B C?	Y	N	Depression	Y	N	Sinus Problems	Y	N
Asthma Inhaler?	Y	N	Hay Fever	Y	N	Pacemaker/Stent Valve/Bypass	Y	N	Tuberculosis	Y	N
Blood Disease	Y	N	Head Injuries	Y	N	Heart Attack Date:	Y	N	Tumors	Y	N
Cancer Type_____	Y	N	Chemotherapy	Y	N	Radiation Treatment	Y	N	Ulcers	Y	N
Dizziness	Y	N	Heart Murmur	Y	N	Respiratory problems	Y	N	Digestive problems	Y	N
Codeine allergy	Y	N	Penicillin allergy	Y	N	Pregnant? Due date:	Y	N	Other medical Problems	Y	N
ADHD	Y	N	Autism spectrum	Y	N	Heart disease	Y	N			

Do you have any allergies, including medication, latex, etc.? Y N
If so, please list them:_____

List all medications you are currently taking, including over-the-counter medicines:

_____

Have you ever had any complications following dental treatment? Y N
If yes, please explain: _____

What are your concerns related to your teeth/mouth? _____

Is there anything else we should know about your medical, dental, or mental health? Y N

If yes, please explain:

Have you ever taken bisphosphonates such as: Fosamax, Boniva, Actonel, Aredia, Zometa, Reclast, for osteoporosis or cancer treatment? Y N

SIGNATURE of patient or guardian_____ DATE _____

Dentist/Hygienist Signature _____ DATE _____

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Informed Consent for Treatment

I give consent for myself/legal ward/my child to receive dental treatment deemed necessary by the providers at MarillacHealth. These procedures include, but are not limited to; examinations, radiographs, prophylaxis (cleanings), sealants, restorations, (fillings and crowns) , periodontal (gum) treatment, endodontic (root canal) treatments, extractions, and the use of local anesthetics. I understand that the use of local anesthetics carries a small risk for swelling, ulceration, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia. This consent shall be considered in effect until rescinded or revoked.

I understand that my prescription history may be obtained from any pharmacy I may have used or the Colorado PDMP website

I understand that MarillacHealth Dental Program charges fees for services, and that all charges are due at the time of service. I understand that any payment or deposit for any prosthetic appliances ordered on my behalf by MarillacHealth is non-refundable.

I understand that only patients will be allowed in the treatment area. It is my responsibility to provide childcare while a dentist is seeing me. I also understand that I cannot leave my children unsupervised in the waiting room.

I understand that I may be referred to another Dentist for services outside the practice.
I understand that MarillacHealth shall not be responsible for any dental bill incurred outside of this office

Assignment of Benefits/ Medicare and Medicaid

I certify that the information given by me in applying under Title XVIII of the Social Security Act is correct. I authorize the Clinic to release to the Social Security Administration or its intermediaries or carriers or insurance companies any information needed for this, or a related Medicare/Medicaid claim or a private insurance claim.
I assign the benefits payable for the dental services to the organization furnishing the services.
I understand this entire consent, financial responsibility and assignment of benefits from the signature date on this form for one year

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Commitment to Safeguard Your Protected Health Information.

Each time you visit our facility, a record of your visit is made. Information about you, including demographic information, that may identify you, this is protected health information ("PHI"). Your medical/dental record is a means of communication among the many health professionals who care for you. PHI may include documentation of your symptoms, examination, diagnoses, and treatment. It also includes documents related to billing and payment for care provided.

We are committed to protecting the privacy of your protected health information. We are required by law to:

- Maintain the privacy of your protected health information.
- Provide you with this Notice about our privacy practices that explains how, when, and why we use and disclose your protected health information.
- Abide by the terms of the current Notice.
- Make a good faith effort to obtain your written acknowledgment that you have received this Notice; and
- Notify you following a breach of your unsecured protected health information.

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Zero Tolerance Policy

MarillacHealth has a zero-tolerance policy. Patients may ultimately be dismissed from the practice and removed from a Provider's panel for failing to abide by this policy. If dismissed, patients will be informed in writing and will not be allowed back into any of the Marillac facilities or department. Aggressive/abusive behavior is not tolerated, and each event is discussed and recorded. Aggressive/abusive patients may be escorted or removed from the facility by security or the police. If removed by the police, patients may be charged with trespassing or charged with criminal charges.

No- show Policy

MarillacHealth has a "no-show" policy to ensure our providers are available for patient's needing medical and dental care.

- If the patent has not called to confirm the appointment by 12:00 pm the business day before the scheduled appointment, *the appointment will be cancelled,* and the time slot will be given to another patient.
- Patients will be allowed three no shows in a twelve-month period.
- After the third no-show, patients will only be allowed "same-day" appointments, if available.
- Patients who fail to show for a "same-day" appointment may be dismissed from the dental practice.
- If Patient is more than 10 minutes late for an appointment, the appointment will be canceled.
- Arrival/check-in time to an appointment is 15 minutes before the scheduled appointment time.

By signing below, I acknowledge that I have read and understand all information included in the Dental policies document.

Note: If you would like a full copy of the policies, please ask the front desk associate.

If minor, name of Patient _____ DOB _____

Today's date _____

Signature of Patient or Legal Guardian _____ DOB _____

PRINTED Name of Patient or Legal Guardian _____

Legal Guardian Relationship to Patient _____

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VERBAL COMMUNICATION CONSENT

Patient Last Name _____First _____Middle _____

Date of Birth _____ Phone number _____

Verbal Disclosure

I authorize Marillac Health to leave messages regarding dental information pertaining to my care by the following methods and will assume responsibility to notify Marillac Health when the information changes.

Home Phone _____ Work Phone _____ Cell Phone _____ Voicemail/Answering Machines _____

Disclosure to other persons

I authorize Marillac Health to speak with the following individual(s) regarding my current dental care and treatment:

Name _____ Relation _____ Phone #_____

Name _____ Relation _____ Phone #_____

Name_____ Relation _____ Phone #_____

All health/dental information, including billing, may be communicated to the above listed individuals except for the following:

_____

This authorization will automatically expire 1 year from the date signed below unless I request an expiration date less than 1 year.

I may revoke this authorization in writing at any time, except to the extent that action has already been taken to comply with it.

Information disclosed pursuant to the authorization may be subject to redisclosure by the recipient and is no longer protected by the HIPAA Privacy Rule.

My signature is required to validate this authorization. If I do not sign this authorization Marillac Health will still provide treatment and seek payment for services provided. According to State Statures, this care site may charge for copies of medical records.

Patient or Parent/Legal Guardian Signature_____

Date _____