

Augusta Regional Dental Clinic

MEDICAL ALERT: _____

Medical and Dental History

Patient Name: _____ Date Of Birth: _____ Medicaid ID # _____

1.) Why are you here today? _____

2.) Are you having pain or discomfort at this time? Yes No

If yes, what type and where? _____

3.) Have you been under the care of a physician during the past two years? Yes No

Name: _____ Telephone: _____

Address: _____

4.) Are you currently taking any medication, drugs, or pills? Yes No

If yes, please list medications: _____

5.) Are you aware of being allergic to or have you ever reacted badly to any medication or substance? Yes No

If yes, please list allergies/reactions: _____

6.) Do you have or have you had any disease, or condition not listed below? Yes No

If yes, please list: _____

Heart Disease or Attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Artificial Joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis A (infectious)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Failure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis B (serum)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Angina Pectoris	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis C	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Congenital Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Arteriosclerosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No
HIV Positive	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Blood Transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mitral Valve Prolapse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cortisone Medication	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cold Sores/Fever Blisters	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cosmetic Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Artificial Heart Valve	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sickle Cell Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bruise Easily	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Yellow Jaundice	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergies or Hives	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hay Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatism	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sinus Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy or Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fainting or Dizzy Spells	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pain in Jaw Joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nervousness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chemotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hay Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Radiation Therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Drug or Alcohol Addiction	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Herpes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric Treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tobacco	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Alcohol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully.

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

Dentist's Signature: _____ **Date:** _____

For Women Only:

1.) Are you pregnant? Yes No 2.) Are you nursing? Yes No 3.) Are you taking birth control pills? Yes No

If yes, what month of pregnancy are you in? _____

Review Date	Changes in Health Status	Patient's Signature	Dentist's Signature

Augusta Regional Dental Clinic
CONSENT FOR TREATMENT/RELEASE/DEEMED CONSENT

FOR YOUR INFORMATION: Some of our dental providers volunteer their service without payment, whether at The Augusta Regional Dental Clinic or by referral to their office; and because they freely donate their time, they are protected from malpractice by a Virginia Law.

TREATMENT: I understand that patients are expected to be active partners in maintaining their dental health, and in return, can expect the Dental Clinic to assist them to the extent that its resources allow.

Dental care is limited to the Dental Clinic's hours of operation when a Dental provider is available. Should you experience any emergency situation, it is your responsibility to seek care at the Augusta Medical Center Emergency Department or other appropriate facility of your choice.

We cannot sponsor patients for emergency room, but you should apply for Financial Assistance through the hospital's business office if you need the use of the emergency room.

CONSENT FOR TREATMENT: By requesting care in the Dental Clinic, I am giving the Dental provider permission to examine, diagnose, and treat me.

RELEASE OF INFORMATION: I give permission to the Dental Clinic to access information concerning my prior care at Augusta Medical Center or from other providers, if deemed necessary for current treatment.

I also give the Dental Clinic permission to release information concerning myself to the hospital or another medical/dental provider if needed for my care.

RELEASE OF INFORMATION TO/FROM MY PHYSICIAN: As I consider Dr. _____ to be my regular doctor, the Dental Clinic provider has permission to contact him/her if it is thought necessary to provide quality health/dental care.

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B & C BLOOD TESTING: The Virginia Code authorizes health care providers to test patients for HIV and Hepatitis B & C when providers or someone employed by/under direction or control of provider is exposed to bodily fluids of the patient in a manner which, according to current guidelines of the Center for Disease Control, may transmit HIV or Hepatitis B or C viruses. In the event of such an exposure, I am deemed to have consented to testing and release of results to person(s) exposed. **HOWEVER,** I will be counseled before any of my blood is tested for HIV or Hepatitis B or C, as well as afterwards when I receive the results.

These permissions may be cancelled in writing by me at any time, but otherwise, are in effect while I am a patient of the Dental Clinic. By signing this form I am certifying that I understand the meaning of the above statements.

Pt. Name: _____

Medicaid ID: _____

Pt/Guardian
Signature: _____

Date: _____

Clinic Rep
Signature: _____

Augusta Regional Dental Clinic – Patient Information Form

Date: _____ Medicaid ID: _____

Patient Name: _____
Address: _____
City, ST Zip _____
Social Security #: _____

Race: Black Hisp White Other

Number in Family: 1 2 3
 4 5 or more

Date of Birth: _____ Age: _____

Guarantor/Guardian: _____

Gender: M F Home Phone: _____

Marital Status: _____ Work Phone: _____

Single Cell Phone: _____

Married Fax: _____

Divorced Pager: _____

Widowed E-Mail: _____

Where or how did you hear
about us? _____

Education Level: 1. College Degree – 4 Years +
 2. Associate College Degree
 3. GED 4. High School Deg
 5. Less than High School Degree
If Student: 6. Grade 6-12 7. Elementary School
 8. FT College 9. PT College

Employment Status: A. Child B. Disabled
 C. Full Time D. Part Time E. Retired
 F. Self-emp'd G. Unemployed H. FT Student

Name of School/Employer: _____

When did you last have your teeth cleaned? _____

If Patient is a Child:

Name of the person bringing the child to the appointment:
_____ Relationship: _____

Parent or Guardian Information:

Name: _____

Address: _____

City, ST, Zip: _____

Phones: H: _____ W: _____ C: _____

Employer: _____

Do you have dental/other insurance?
 No, I do not have any insurance
 Yes, through Medicaid, ID: _____
(Medicaid card must be presented to clinic for verification)

Yes, through another plan:
Plan Name: _____
Subscriber ID: _____

What county do you live in? _____

Emergency Contact – Name: _____

Phone Number: _____

I have read and understand all information on this form, and I hereby affirm that the information I have provided above is true and correct to the best of my knowledge and belief.

Signature of Patient, or of
Parent or Guardian if minor: _____

For Clinic and Staff Use Only – Patients, do not write in this space.

Eligibility: Expires: _____

Education Level: ED Patient Type: Medicaid 35PP Voucher
(Fee Schedule)

Office Code: _____ Chart #: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

Augusta Regional Dental Clinic
342 Mule Academy Rd.
Fishersville, VA. 22939

Section A: The Patient.

Name: _____ Medicaid ID: _____

Address: _____

Telephone: _____

Social Security Number: _____

Section B: Acknowledgement of Receipt of Privacy Practices Notice.

I, _____, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: _____ Date: _____

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____



P.O. Box 153 Fishersville, VA 22939 (540)-332-5619 dentalclinic@ntelos.net

Augusta Regional Dental Clinic is dedicated to providing affordable and quality dental care to as many residents of Staunton, Waynesboro and Augusta County as possible, who otherwise might not have access to care. In dentistry, there are many treatment choices available for patients. We want to work with you to find the best solution for your dental needs.

FILLING MATERIALS

We provide white (composite) fillings for fillings in the front teeth for aesthetics, and silver (amalgam) fillings to restore back teeth for proven durability. Amalgams are an accepted dental filling material approved by the American Dental Association (ADA), Food and Drug Administration (FDA), and the World Health Organization (WHO). If you desire white (composite) fillings in back teeth, we respectfully ask you find a private practice provider to provide the treatment for you.

CROWNS AND ROOT CANAL TREATMENT

We currently offer limited Crown and Root Canal coverage to minors (and individuals under 21) who have adequate Medicaid coverage. Depending on the location of the crown, some metal may show. If you have questions about this, please ask us.

EXTRACTIONS AND EMERGENCIES

We work hard to accommodate dental emergencies to alleviate infection and pain. If you are experiencing dental pain or swelling, please call us so we can help. If you have had antibiotics prescribed by another doctor, please let us know as soon as possible.

DENTURES

We currently do not offer dentures or partials, but we will be happy to provide you with the contact information of those who provide and service dentures at reasonable rates.

If you have any questions/concerns regarding your (or a loved one's) dental treatment, please ask the dentist or an assistant BEFORE the dental procedure. We will be happy to answer any questions you might have.

I acknowledge that I have read and understand the above information

Signed: _____ Date: ____/____/____



P.O. Box 153 Fishersville, VA 22939 (540)-332-5619 dentalclinic@ntelos.net

Photo Release

I give permission to the Augusta Regional Dental Clinic (ARDC) to take my photo/my child's photo and release the picture and my name/child's name along with pertinent information to the local media, or to be used by the ARDC for promotional use.

Name of Patient/Child

Signature of Patient/Parent/Guardian

Date

Augusta Regional Dental Clinic

The mission of the Augusta Regional Dental Clinic is to provide dental related services to those persons and their families, who are making a sincere effort to support themselves, are income qualified, but who do not have the means to pay the full cost for such services.

Patient Policies

1. Patient Appointment Policies

Confirmation: The ARDC will attempt to confirm your appointment 48 hours prior to the appointment date. However, you must contact the clinic by Noon the day prior to your appointment to confirm, failure to do so will result in the appointment being cancelled and we will be unable to reschedule you for six months or longer due to the volume of future patient appointments. If your phone is disconnected, unable to receive messages, or if we are unable to leave a message, the appointment will be cancelled and we will be unable to reschedule you for six months or longer due to the volume of future patient appointments. Please arrive for your scheduled appointments on time. If you arrive more than 5 minutes late, we may reschedule your appointment and you will lose your pre-paid deposit. You must give at least 24 hours notice if an appointment is being cancelled or rescheduled. This policy applies to appointments with off-site dentists or dental specialist.

Cancellations/No Shows: If you do not provide 24 hour notice to cancel or reschedule an appointment, we will be unable to reschedule you for six months or longer due to the volume of future patient appointments and you will lose your pre-paid deposit. Two No-Shows within a 12 month period means your clinic privileges are suspended indefinitely and you will lose your pre-paid deposit. One missed appointment with off-site dentists or dental specialist will result in being suspended indefinitely and you will lose your pre-paid deposit.

2. Treatment Plan Policy

If patient does not agree with the treatment plan, and their non-compliance jeopardizes the ARDC's ability to deliver an acceptable standard of care, or the patient insists upon a treatment that is not feasible at the clinic, patient will be required to seek care in private practice, or be dismissed from the clinic based on the individual situation.

3. Patient Conduct Policy

The Dental Clinic is here to provide you with the best care possible. Be respectful and cooperative to ARDC staff members as well as other ARDC patients; rude behavior or profane language will not be tolerated. Any patient thought to be intoxicated or chemically impaired at anytime, will be denied services or treatment and faces possible dismissal from the clinic. Failure to abide by these responsibilities will result in denial of services at the ARDC. The ARDC reserves the right to determine whether a patient shall or shall not receive services at our Clinic. If you have a complaint or concern about the service you have received from the dentists or any of the staff working in this practice, please let us know. Our complaints system adheres to state criteria. When adults are being treated, their children may not accompany them into the dental operator. The dental department cannot provide childcare while a parent is being treated.

4. Contact Information Policy

It is your responsibility to keep your contact information updated with the clinic. The clinic will make every attempt to contact you in reference to your appointments & dental treatment.

5. Payment Policy

There is a co-payment for EACH dental visit and the co-payment is \$35. Advance payment is required and must be either cash or money order. **NO CHECKS OR CREDIT CARDS ACCEPTED!**

I have read and understood the above Augusta Regional Dental Clinic policies.

Patient Signature

Date



P.O. Box 153 Fishersville, VA 22939 (540)-332-5619 dentalclinic@ntelos.net

If English is your second language and you are unable to understand clinic policies and procedures, clinical/medical questions or instructions, or any other related part of your treatment and/or care, it is your responsibility to have a translator over the age of 18 with you during the eligibility paperwork and at EVERY clinical appointment. If a translator is not present, services or treatment will be denied and you face possible dismissal from the clinic.

Si usted no habla Ingles y si no le es posible de que puedas entender las reglas y procedimientos, preguntas del medico o instrucciones o cualquier parte de su tratamiento, es su reponsabilidad de tener a un traductor que tenga mas de 18 anos de edad. El traductor tiene que estar con usted duranted el papeleo de la elegibilidad y a CADA sita. Si un traductor no esta presente at tiempo de la sita, el tratamiento sera negado y usted corre la posibilidad de ser despedido de la clinica.

I have read and understand the above Augusta Regional Dental Clinic policy.

Patient Signature

Date

Witness

Date