

# DENTAL PATIENT - MEDICAL HISTORY/ HISTORIA MEDICA DEL PACIENTE

(PLEASE PRINT/ POR FAVOR, ESCRIBA CON LETRA DE IMPRENTA)

Date / Fecha \_\_\_\_\_ Home Phone / Teléfono de Casa (\_\_\_\_\_) \_\_\_\_\_  
Patient / Paciente \_\_\_\_\_  
Last Name / Apellido \_\_\_\_\_ First Name / Primer Nombre \_\_\_\_\_ Middle Initial / Segundo Nombre \_\_\_\_\_ Preferred Name / Nombre Preferido \_\_\_\_\_  
Street Address / Dirección \_\_\_\_\_ City / Ciudad \_\_\_\_\_  
State / Estado \_\_\_\_\_ Zip / Código Postal \_\_\_\_\_ Cell Phone / Teléfono celular (\_\_\_\_\_) \_\_\_\_\_  
Birthdate / Fecha de Nacimiento \_\_\_\_\_ Age / Edad \_\_\_\_\_ Sex / Sexo  M  F  
Social Security Number / Numero de Seguro Social \_\_\_\_\_  
In Case of emergency, who should be notified? / ¿En caso de emergencia, quién debe ser notificado? \_\_\_\_\_  
Phone / Teléfono (\_\_\_\_\_) \_\_\_\_\_  
Whom may we thank for referring you? / ¿A quién le podemos dar las gracias por haberlo referido? \_\_\_\_\_

## MEDICAL HISTORY / HISTORIA MEDICA

Physician's Name / Nombre de su Medico \_\_\_\_\_ Date of Last Physical / Fecha del último Examen Físico \_\_\_\_\_  
Have you ever had any of the following? (check boxes that apply) / ¿Ha tenido usted cualquiera de los siguientes? (marque los cuadros que le correspondan):

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Allergies/Alergias                                       | <input type="checkbox"/> Heart Murmur/Soplo en el Corazón                 | <input type="checkbox"/> Psychiatric Care/Cuidado Psiquiátrico   |
| <input type="checkbox"/> Arthritis/Artritis                                       | <input type="checkbox"/> Heart Problems/Problemas del Corazón             | <input type="checkbox"/> Radiation Treatment/Tratamiento de Radiación  |
| <input type="checkbox"/> Artificial Heart Valves/Válvulas Artificiales de Corazón | <input type="checkbox"/> Hemophilia/Hemofilia                             | <input type="checkbox"/> Recent Weight Loss/Pérdida de Peso reciente   |
| <input type="checkbox"/> Asthma/Asma  | <input type="checkbox"/> Hepatitis/Hepatitis                              | <input type="checkbox"/> Respiratory Disease/Enfermedad Respiratoria   |
| <input type="checkbox"/> Back Problems/Problemas de la Espalda                    | <input type="checkbox"/> High Blood Pressure/Presion alta de Sangre       | <input type="checkbox"/> Rheumatic Fever/Fiebre Reumática  |
| <input type="checkbox"/> Bleeding Abnormally/Sangrado Irregular                   | <input type="checkbox"/> HIV/AIDS VIH/SIDA                                | <input type="checkbox"/> Seizure/Epilepsia   |
| <input type="checkbox"/> Blood Disease/Enfermedad de la Sangre                    | <input type="checkbox"/> Joint Replacement/Reemplazo Conjunto             | <input type="checkbox"/> Sinus Problem/Problema de Sinusitis   |
| <input type="checkbox"/> Cancer/Cáncer  | <input type="checkbox"/> Kidney Problems/Problemas del Riñón              | <input type="checkbox"/> Special Diet/Dieta especial   |
| <input type="checkbox"/> Chemical Dependency/Dependencia Química                  | <input type="checkbox"/> Liver Problems/Problemas del Hígado              | <input type="checkbox"/> Stroke/Embolia Cerebral   |
| <input type="checkbox"/> Chronic Diarrhea/Diarrea Crónica                         | <input type="checkbox"/> Low Blood Pressure/Presion baja de Sangre        | <input type="checkbox"/> Swollen Neck Glands/Glándulas del Cuello Hinchadas                                      |
| <input type="checkbox"/> Circulatory Problems/Problemas Circulatorios             | <input type="checkbox"/> Mitral Valve Prolapse/Prolapso Mitral de Válvula | <input type="checkbox"/> Thyroid/Tiroides <input type="checkbox"/> Hyper/Alto <input type="checkbox"/> Hypo/Bajo |
| <input type="checkbox"/> Congenital Heart Lesions/Lesiones Congénitas de Corazón  | <input type="checkbox"/> Nervous Problems/Problemas Nerviosos             | <input type="checkbox"/> Ulcer/ Ulcera   |
| <input type="checkbox"/> Diabetes/ Diabetes                                       | <input type="checkbox"/> Osteoporosis/Osteoporosis                        | <input type="checkbox"/> Venereal Disease/Enfermedad Venérea   |
| <input type="checkbox"/> Headaches/Dolores de Cabeza                              | <input type="checkbox"/> Pacemaker/Marcapasos                             |  |

When was your last dental visit? / ¿Cuándo fue su última visita al dentista? \_\_\_\_\_ For what procedure? ¿Para qué procedimiento? \_\_\_\_\_

Do you have any drug allergies or have you ever had an adverse reaction to any medication or anesthesia? ¿Tiene alergias a alguna droga o ha tenido usted una reacción adversa a cualquier medicina o anestesia?  Yes/Sí  No

If so, what? / Si la respuesta es afirmativa, ¿a qué? \_\_\_\_\_

Have you ever responded adversely to medical or dental treatment? / ¿Ha reaccionado usted adversamente a un tratamiento médico o dental? \_\_\_\_\_

Please list any medication you are taking at this time. / Por favor liste cualquier medicamento que usted esté tomando en este momento. \_\_\_\_\_

Have you ever taken any of the groups collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine) / ¿Alguna vez ha usted tomado cualquiera de los grupos segun referidos colectivamente como el "fenfen"? Esto incluye combinaciones de Ionimin, Adipex, Fastin (nombres de marca de fentermina), Pondimin (fenfluramina) y Redux (dexfenfluramina)  Yes/Sí  No

Have you ever taken pills or received shots that are bone density drugs/ Bisphosphonates? Some examples are Actonel, Actonel+Ca, Aredia, Boniva, Didronel, Fosamax, Fosamax+D, Reclast, Skelid, Zometa. ¿Ha tomado usted pastillas o ha recibido inyecciones de drogas que son para la densidad de hueso? Por ejemplo Actonel, Actonel+Ca, Aredia, Boniva, Didronel, Fosamax, Fosamax+D, Reclast, Skelid, Zometa.  Yes/Sí  No

Are you under the care of a physician? / ¿Está bajo el cuidado de algún doctor?  Yes/Sí  No

For what conditions? / ¿Para qué tipo de condición médica? \_\_\_\_\_

(Women) Do you suspect that you are pregnant? / (Mujeres) ¿Sospecha que usted está embarazada?  Yes/Sí  No

Due date / Fecha de parto \_\_\_\_\_ Are you nursing? / ¿Esta usted dando pecho?  Yes/Sí  No

Taking birth control pills? / ¿Está tomando píldoras anticonceptivas?  Yes/Sí  No



# Heart City Health

## Patient Registration

Date \_\_\_\_\_ Email address \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Social Security Number \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone Number \_\_\_\_\_

US Citizen? \_\_\_\_\_ Are you a student? \_\_\_\_\_ Race \_\_\_\_\_ Marital Status \_\_\_\_\_

Occupation \_\_\_\_\_ Primary language \_\_\_\_\_ Referred by \_\_\_\_\_

If patient is under 18, who is responsible for the account? \_\_\_\_\_

Relationship with Patient \_\_\_\_\_

### List all people in your house, their age and relationship to you:

Name	Age	Relationship	Medicaid?	Working?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

### Monthly Household Income (Circle the most accurate answer)

\$0-\$600    \$600-\$1200    \$1201-\$1800    \$1801-\$2400    \$2401-\$3000    \$3000+

Employer \_\_\_\_\_ Phone Number \_\_\_\_\_

School \_\_\_\_\_ Phone Number \_\_\_\_\_

In case of emergency, please contact \_\_\_\_\_ Phone Number \_\_\_\_\_

How did you hear about us?    \_\_\_ Billboard    \_\_\_ Center for Healing & Hope    \_\_\_ Faith Mission

\_\_\_ Health Coalitions    \_\_\_ Radio    \_\_\_ TV    \_\_\_ Website    \_\_\_ Word of Mouth    \_\_\_ Other \_\_\_\_\_



# Heart City Health

## UDS Demographic Data Collection

As a Federally Qualified Health Center (FQHC) receiving federal funding, Heart City Health Center is required to gather information from patients that can be reported back to the federal government annually, enabling us to continue to pass along affordable healthcare options in Elkhart. We kindly ask you to take a moment to answer the following questions.

ESTIMATED MONTHLY HOUSEHOLD INCOME (Circle the most accurate estimate)

\$0-\$600    \$600-\$1,200    \$1,201-\$1,800    \$1,801-\$2,400    \$2,401-\$3,000    \$3,001+

FAMILY SIZE: \_\_\_\_\_

SOCIAL DEMOGRAPHICS: (Please check the box next to most accurate response)

Gender Identity		Sexual Orientation	
Male		Lesbian, gay or homosexual	
Female		Straight or heterosexual	
Transgender Male (Female-to-Male)		Bisexual	
Transgender Female (Male-to-Female)		Something else	
Gender queer		Don't Know	
Other		Choose not to disclose	
Choose not to disclose			
<b>Miscellaneous</b>			
Agricultural			
Homeless			
Military Veteran			

**Thank you for taking the time to provide this information for federal reporting purposes.**

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Responsible Person or Legal Guardian's Name

\_\_\_\_\_  
Relationship with Patient

\_\_\_\_\_  
Date



## Heart City Health

### Financial Agreement

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me or the patient. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

\_\_\_\_\_  
Signature of Patient, Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print patient's name, Parent or Guardian

\_\_\_\_\_  
Relationship to patient

### Notice of Privacy Practice Acknowledgement

By signing below, I acknowledge that I have received a written copy of Heart City Health Center's, Inc. Notice of Privacy Practices and Rights and Responsibilities.

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
DOB

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Responsible Person or Legal Guardian's Name





# Heart City Health

## Medical Treatment Authorization and Consent Form of a Minor

The following form is designed for those situations where minors are unaccompanied by either parent or legal guardians. This “Medical Treatment Authorization and Consent Form of a Minor” gives authority to a designated adult to arrange for medical care for a minor in the absence of the parent/legal guardian.

I \_\_\_\_\_ being the parent/legal guardian of \_\_\_\_\_  
**Parent or Legal Guardian** **Patient's Name**  
hereby authorize the following individual/s to give informed consent to any and all medical, dental care, treatment and/or attention for my child/ward which is deemed necessary and appropriate by a Heart City Health Center, Inc. provider in my absence.

Name	Relationship to Patient	DOB
Name	Relationship to Patient	DOB
Name	Relationship to Patient	DOB

**Initial** the box next to your choice.

**This authorization:**

**Expires** on: \_\_\_/\_\_\_/20\_\_\_ upon which I will sign a new authorization.

**or**

Is **Open-Ended** (I understand that I have to notify Heart City Health Center, Inc. if I decide to revoke this authorization and that Heart City Health Center, Inc. will accept my decision to revoke).

I understand that I can revoke this authorization at any time by communicating this in writing or verbally to Heart City Health Center, Inc. staff.

X \_\_\_\_\_  
**Signature** of Parent or Legal Guardian \_\_\_\_\_  
Date

I declare that I witnessed the signing of this document by the parent or the legal guardian on the date noted above.

\_\_\_\_\_ \_\_\_\_\_  
HCHC Staff Signature Printed Name



**Heart City Health**

## **Permission to Disclose Confidential Protected Health Information**

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
DOB

**I give my permission for my health information to be released to the following:**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
DOB

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
DOB

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
DOB

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date



# Heart City Health

## Advanced Directives Acknowledgement Form

Heart City Health Center, Inc. recognizes the rights of all adult individuals with decision making capacity to participate in decision making concerning their health care and medical treatment. Advanced Directives shall be followed by Heart City Health Center, Inc. to the extent permitted and required by Indiana Law.

Heart City Health Center, Inc. respects the right of individual choice in executing or not executing Advanced Directives for health care and medical treatment. We do not condition the provision of medical care or discriminate against an individual based on whether or not an Advanced Directive has been executed.

Heart City Health Center, Inc. is committed to the education of our own employees, as well as the community, regarding their rights to formulate Advanced Directives and the right of individuals to consent to or refuse medical treatment.

For the purpose of this policy, “Advanced Directives” means a written instruction such as a Living Will Declaration, Life Prolonging Procedure Declaration, and Appointment of Health Care Representative, or Power of Attorney for health care purposes. These Advance Directives are established under Indiana Law and relate to the provision of medical care when an individual is incapacitated.

If you have an Advanced Directive, Living Will Declaration, or Life Prolonging Procedure Declaration, Heart City Health Center, Inc. will ask you to provide a copy to store in your current health record.

Date \_\_\_\_\_

Yes, I have an advanced directive \_\_\_\_\_

Signature

No, I do not have an advanced directive \_\_\_\_\_

Signature





# INDIANA HEALTH CARE REPRESENTATIVE APPOINTMENT

State Form 56184 (11-16)

Indiana State Department of Health – IC 16-36-1; IC 16-36-6

*INSTRUCTIONS: See instructions on back.*

Patient / Appointor Information		
Patient Last Name	Patient First Name	Patient Middle Initial
Patient Birthday ( <i>mm/dd/yyyy</i> )	Medical Record Number of Healthcare Facility or Provider ( <i>optional</i> )	Healthcare Facility or Provider ( <i>optional</i> )
Appointment of Health Care Representative		
<p>I, being at least eighteen (18) years of age, of sound mind, and capable of consenting to my health care, hereby appoint the person(s) named below as my lawful health care representative in all matters affecting my health care, including but not limited to providing consent or refusing to provide consent to medical care, surgery, and/or placement in health care facilities, including extended care facilities, unless otherwise provided in this appointment. This appointment shall become effective at such time and from time to time as my attending physician determines that I am incapable of consenting to my health care. I understand that if I have previously named a health care representative the designation below supersedes (replaces) any prior named Health Care Representative(s).</p> <p>I authorize my health care representative to make decisions in my best interest concerning withdrawal or withholding of health care. If at any time based on my previously expressed preferences and the diagnosis and prognosis my health care representative is satisfied that certain health care is not or would not be beneficial or that such health care is or would be excessively burdensome, then my health care representative may express my will that such health care be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or not instituted, even if death may result. My health care representative must try to discuss this decision with me. However, if I am unable to communicate, my health care representative may make such a decision for me, after consultation with my physician or physicians and other relevant health care givers. To the extent appropriate, my health care representative may also discuss this decision with my family and others to the extent they are available.</p> <p>I specify the following terms and conditions (<i>if any</i>):</p>		
Name of Representative Appointed	Address of Representative ( <i>number and street, city, state, and ZIP code</i> )	Telephone Number of Representative
Signature of Patient / Appointor or Designee ( <i>must be signed in the appointor's presence</i> )	Printed Name of Patient / Appointor or Designee	Date of Appointment ( <i>mm/dd/yyyy</i> )
Signature of Witness	Printed Name of Witness	Date ( <i>mm/dd/yyyy</i> )

## INSTRUCTIONS FOR STATE FORM 56184, INDIANA HEALTH CARE REPRESENTATIVE APPOINTMENT

1. There are numerous types of advance directives. The Indiana State Department of Health encourages individuals to consult with their attorney, health planner, and health care providers in completing any advance directive.
2. This state form is not required for an appointment of a health care representative. An individual may use a form designed by their attorney or other entity to specifically meet the individual's needs. To be valid, any form must comply with statutory requirements.
3. An individual is not required to complete a health care representative appointment form. An individual may always choose to not appoint a health care representative. If there is no appointed representative, state medical consent laws would determine who may consent to your healthcare.
4. The medical record number and health care facility or provider is not required for the appointment to be effective. It may be included as a means of assisting the health care provider in identifying the correct patient and locating the appointment in the correct medical record.
5. The patient / appointor may specify in the appointment appropriate terms and conditions, including an authorization to the representative to delegate the authority to consent to another.
6. The authority granted becomes effective according to the terms of the appointment.
7. The appointment does not commence until the appointor becomes incapable of consenting. The authority granted in the appointment is not effective if the patient / appointor regains the capacity to consent.
8. Unless the appointment provides otherwise, a representative appointed under this section who is reasonably available and willing to act has priority to act in all matters of health care for the patient / appointor, except when the patient / appointor is capable of consenting.
9. The appointment of a health care representative must be witnessed by an adult other than the health care representative.
10. In making all decisions regarding the patient's / appointor's health care, the health care representative shall act:
  - a. In the best interest of the patient / appointor consistent with the purpose expressed in the appointment.
  - b. In good faith.
11. A health care representative who resigns or is unwilling to comply with the written appointment may not exercise further power under the appointment and shall so inform the following:
  - a. The patient / appointor.
  - b. The patient's / appointor's legal representative if one is known.
  - c. The health care provider if the representative knows there is one.
12. An individual who is capable of consenting to health care may revoke:
  - a. The appointment at any time by notifying the representative orally or in writing; or
  - b. The authority granted to the representative by notifying the health care provider orally or in writing.



# Heart City Health

## Rights and Responsibilities

Staff members at Heart City Health Center, Inc. are dedicated to providing you with the best possible care and treatment. As a participant in your health care, your Rights and Responsibilities at Heart City Health Center, Inc. are:

### **Rights:**

1. You will be treated with courtesy.
2. You are entitled to information concerning your diagnosis, treatment, and prognosis.
3. You have the right to participate in making decisions regarding your health care.
4. You have the right to know the names of the people caring for you and their role in your treatment.
5. You may look at or obtain copies of your medical records. A fee will be charged for copies.
6. You may expect privacy and safe surroundings while you are at the center.
7. You may expect that information and records about your care will be kept confidential.
8. You will be notified in advance whenever possible, when your provider cannot keep an appointment.
9. You may ask questions if you are dissatisfied with your care.
10. You will not be discriminated against because of your race, religion, color, national origin, gender, age, political beliefs, handicaps, marital status, sexual preference, or source of payment.
11. You have a right to the best possible care. You will not be deprived of any benefits, rights or privileges guaranteed by federal or state law.

### **Responsibilities:**

1. You are expected to observe Heart City Health Center, Inc. rules.
2. You must have an appointment to see a provider.
3. If you cannot keep a scheduled appointment, it is your responsibility to call and cancel before your scheduled appointment time. Three (3) missed appointments, (No Call or No Show) will result in seeing the provider on a walk-in basis, for 6 months from your last NO Show appointment.
4. Tell your provider as accurately as you can all about your past illnesses and your present condition, including hospital stays, seen another doctor in the past, taking medications, bring a list of medications with dosages.
5. If your condition changes, or if you have a problem with your treatment, tell your provider immediately.
6. If you do not understand your treatment, or what is expected of you, tell your provider immediately.
7. Follow the advice and instructions your provider gives you about your care.
8. If you refuse treatment or do not follow instructions, you may be denied further care at the center.
9. The charge for your treatment is your responsibility. Payment for services is requested at the time of your appointment. You will be billed for any balance owed.



# Heart City Health

**By Signing below I acknowledge that all information within the New Patient Packet is correct, current and accurately stated to the best of my knowledge.**

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
HCHC Staff

\_\_\_\_\_  
Date