Franklin Primary Health Center, Inc.
Medical History Dental Clinic

Chart #_____

Name _____
LAST FIRST MIDDLE

DATE OF BIRTH _____ SEX _____ HEIGHT _____ WEIGHT _____

NAME OF PARENT/GUARDIAN **(If applicable)** _____

PLEASE ANSWER **EACH** QUESTION AND LIST RESPONSES **CHECK ONLY 1 EITHER ( ) YES OR ( ) NO**
{NO SCRATCH OUTS PLEASE}

1. Have you been hospitalized in the past two years? Why? _____ ( )Y ( )N
2. Are you taking any kind of **drugs, medications, vitamins, or herbal supplements**? _____ ( )Y ( ) N
   List any medications you are taking _____
   _____
3. Do you take a blood thinner daily? **(Coumadin, Plavix, Aspirin, Xarelto, Eliquis, Aggrenox)**? _____ ( )Y ( )N
4. **Are you allergic to Penicillin, Codeine, Lidocaine, Erythromycin, Aspirin, Motrin,** _____ ( )Y ( )N
   Sulfa drugs, Tylenol, Latex, Iodine or any other medication? _____

****FEMALES ONLY****

5. Are you (OR) could you be pregnant now? _____ ( )Y ( )N
6. Are you breastfeeding? _____ ( )Y ( )N
7. Are you taking Birth Control? _____ ( )Y ( )N

8. Have you ever had excessive bleeding from tooth extractions? _____ ( )Y ( )N
9. Are you or have you ever taken Oral or Received IV Bisphosphonates used for Bone Problems? **(Ex: Boniva or Fosamax)** ( )Y ( )N

Do you have or have you ever had any of the following: Please check below. **Check either Yes or No**

	YES	NO		YES	NO		YES	NO
Heart Trouble	( )	( )	Sickle Cell Disease or Trait	( )	( )	Thyroid Problems	( )	( )
Heart Attack	( )	( )	Fainting Spells or seizures	( )	( )	Steroid Therapy	( )	( )
Heart Murmur	( )	( )	Hepatitis **A, B or C**	( )	( )	Diabetes	( )	( )
Mitral Valve Prolapse	( )	( )	High Blood Pressure	( )	( )	Dialysis	( )	( )
Endocarditis	( )	( )	Learning Disability	( )	( )	Kidney Problems	( )	( )
Pacemaker	( )	( )	Mental Health Illness	( )	( )	Tuberculosis	( )	( )
Rheumatic Fever	( )	( )	Stomach Ulcers	( )	( )	Liver Disease	( )	( )
Smoker	( )	( )	Knee or Hip Replacement	( )	( )	HIV	( )	( )
Asthma	( )	( )	Cancer	( )	( )	Epilepsy	( )	( )
COPD	( )	( )	Chemo Therapy	( )	( )	Organ Transplant	( )	( )
Lupus	( )	( )	Radiation Therapy	( )	( )	G-6-Pd Deficiency	( )	( )

10. **Do you have any conditions, problems or disease not listed above? If yes, please explain.**
    _____

_____ _____-_____-_____
Patient/Legally Responsible Adult **Date**

_____ _____-_____-_____
Dental Assistant/Hygienist Signature **Date**

This signature signifies that the Dental Assistant and/or Hygienist have reviewed the above information with the patient.

Rev: 10/20

Framklin Primary Health Center, Inc.

GENERAL DENTISTRY INFORMED CONSENT/PATIENT RESPONSIBILITY

(Print Patient Name): _____ **Chart #** _____

Date: _____

Please read, initial & sign all the items listed below.
Do not sign this form or agree to treatment until you have read, understood & accepted.
Any questions you may have or don't understand please do not hesitate to ask.

1. **Patient Behavior:** Due to the exacting nature of dental treatment, special cooperation is required between the dental staff and the patient. Patients under influence of drugs, exhibiting belligerent behavior (such as yelling, complaining about being at the clinic, arguing about proposed treatment) or those not following specific instructions will not be acceptable for treatment. If a procedure is out of the scope of the clinic, you will be advised to see a dentist or physician who can better handle your needs. I agree to cooperate completely with the recommendations of my doctor while I am under his/her care. **(Initials _____)**

2. **X-Rays/Imaging:** I consent to taking any x-rays my dentist determines necessary to evaluate my treatment. X-rays are Radiographs and are required to complete your examination, diagnosis and treatment plan. A periodic examination will be provided by the dentist at all routine cleanings to evaluate your teeth for decay, gum disease, oral cancer and overall health. The dentist will read and diagnosis any x-rays taken. **(Initials_____)**

3. **Drug and Medications:** I understand that antibiotics, analgesics, and other medications could cause allergic reactions such redness and swelling of tissues, pain, itching, anaphylactic shock (severe allergic reaction), nausea and vomiting. **(Initials_____)**

4. **Changes in Treatment Plan:** I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered or developed since initial examination. The most common of these is the need for root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary. **(Initials_____)**

5. **Periodontal Loss (Tissue & Bone):** I understand that serious gum problems can lead to bone infection or bone loss and that it can lead to the loss of my teeth. Alternative treatments include gum surgery, replacements and/or extraction. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition. **(Initials_____)**

*****Females Only*****

6. **Pregnancy:** If for any reason I may be I am pregnant, it is my responsibility to notify that assistant and dentist before any radiographic images are taken and prior to receiving any prescriptions from the provider. I will provide proper documentation from my current OB/GYN before any services are rendered. **(Initials_____)**

7. **Birth Control:** **(**Female Only**)** any antibiotics prescribed may potentially interfere with and/or reduce the effectiveness of oral contraceptive pills & a second form of birth control is advised for the duration of the menstrual cycle during which antibiotics were taken. **(Initials_____)**

Consent: I have read each paragraph above and consent to recommended treatment as needed. I understand the details outlined above as well as my patient responsibilities.

_____ _____

Signature of Patient/Guardian **Date:**

_____ _____

Witness/Dental Asst. Signature **Date:**

Board of Dental Examiners of Alabama

5346 Stadium Trace Parkway, Suite 112
Hoover, Alabama 35244
205-985-7267

Mobile Facility or Portable Dental Operation Consent Form

To Be Completed By Operator:

Mobile Facility or Portable Dental Operation Permit number: _____

Issued: _____ Expires: _____

An Operator is a person licensed to practice dentistry in this state or an entity which is approved as tax exempt under Section 501(c)(3) of the Internal Revenue Code which employs dentists licensed in the state to operate a mobile dental facility or portable dental operation. Code of Alabama §34-9-6.1(a)(3).

Operator Name: Franklin Primary Health Center, Inc.

Operator Business Address: 1303 Dr. Martin Luther King, Jr. Ave. Mobile, Alabama 36603

Operator Telephone Number: 251-432-4117

* **Has prospective patient received dental care from a licensed dentist within one year? YES NO**

If Yes, the name, address, and phone number of the Dental Home (The Dental Home is the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. Code of Alabama §34-9-6.1(a)(1)):

* Dental Home: _____ Phone: _____

Dental Home Address: _____

The Operator shall contact the designated Dental Home by phone, facsimile, or electronic mail and notify the Dental Home of the prospective patient's interest in receiving dental care from the Operator.

Date of Contact with Dental Home: _____

Method of Contact: ___ phone ___ facsimile ___ electronic mail

* **Does the prospective patient have scheduled appointment to seek care from the Dental Home? YES NO**

DATE of appointment to seek care from the Dental Home: _____

If the information provided to the Operator does not identify a Dental Home for the prospective patient, the Operator shall contact the Alabama Medicaid Agency for assistance in identifying a Dental Home for the Medicaid eligible patients.

Dental Home information (name, address, and phone number) provided by Alabama Medicaid Agency:

Name: _____ Phone _____

Address: _____

DATE of contact with Alabama Medicaid Agency: _____

Alabama Medicaid Agency Contact Name: _____

If the Dental Home confirmed that an appointment for the prospective patient is scheduled with the dentist, has the Operator encouraged the prospective patient or his or her guardian to seek care from the Dental Home? **YES NO**

Date: _____ Operator: _____

By: _____

Its: _____

To Be Completed by Patient / Parent / Legal Guardian:

Name of prospective patient: _____

Date of Birth: _____

THE PATIENT OR LEGAL GUARDIAN UNDERSTANDS THAT THE PROSPECTIVE PATIENT HAS AN OPTION TO RECEIVE DENTAL CARE FROM EITHER THE MOBILE DENTAL FACILITY OR PORTABLE DENTAL OPERATION OR HIS OR HER DESIGNATED DENTAL HOME IF APPLICABLE.

_____ _____

Date Patient / Parent / Legal Guardian

A copy of this form shall be maintained by the Operator in the patient chart and made available to the Alabama Medicaid Agency and the Board of Dental Examiners of Alabama upon request.

D.O.B. -- _____
Chart No. _____

Franklin Primary Health Center, Inc.

About Our Notice of Privacy Practices

We are committed to protecting your personal health information in compliance with the law. Our Notice of Privacy Practices states:

- our obligations under the law with respect to your personal health information.
- how we may use and disclose the health information that we keep about you.
- your rights relating to your personal health information.
- our rights to change our Notice of Privacy Practices.
- how to file a complaint if you believe your privacy rights have been violated.
- the conditions that apply to uses and disclosures not described in this Notice.
- the person to contact for further information about our privacy practices.

We are required by law to give you a copy of our Privacy Notice and to obtain your written acknowledgement that you have received a copy of this notice.

As a courtesy to our patients we are supplying everyone with a copy of the Advance Directives.

Patient Acknowledgment of Receipt

I, _____, hereby acknowledge that I have
(Print)

received a copy of Franklin Primary Health Center, Inc., Notice of Privacy Practices/Advance Directives Information.

_____

Patient's Signature **Date**

_____

Signature of Parent or Patient's Representative (if applicable) **Date**

_____

_____

Description of Legal Authority to Act on Behalf of Patient

Franklin Primary HEALTH CENTER

CONSENT TO DENTAL TREATMENT

Patients Name: _____ **Date:** _____

DOB: _____ **Chart #:** _____ **Time:** _____

I HEREBY AUTHORIZE DR._____AND HIS/HER ASSOCIATES AT_____
TO PERFORM UPON ME OR THE NAMED PATIENT THE FOLLOWING PROCEDURE(S) IN SPECIFIC DETAILS:

_____

_____

DR._____HAS FULLY EXPLAINED TO ME THE PURPOSE OF THE PROCEDURE(S) AND HAS ALSO INFORMED ME OF EXPECTED BENEFITS AND COMPLICATIONS (FROM KNOWN AND UNKNOWN CAUSES), ATTENDANT DISCOMFORTS AND RISKS THAT MAY ARISE, AS WELL AS POSSIBLE ALTERNATIVES TO THE PROPOSED TREATMENT, INCLUDING NO TREATMENT. THE ATTENDANT RISKS OF NO TREAMENT HAVE ALSO BEEN DISCUSSED. I HAVE BEEN GIVEN AN OPPORTUNITY TO ASK QUESTIONS, AND ALL MY QUESTIONS HAVE BEEN ANSWERED FULLY AND SATISFACTORILY. I ACKNOWLEDGE THAT NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME CONCERNING THE RESULTS INTENDED FROM THE PROCEDURE(S).

I UNDERSTAND THAT DURING THE COURSE OF THE PROCEDURE(S), UNFORSEEN CONDITIONS MAY ARISE WHICH NECESSITATE PROCEDURES DIFFERENT FROM THOSE CONTEMPLATED. I, THEREFORE, CONSENT TO THE PERFROMANCE OF ADDITIONAL PROCEDURE(S) WHICH THE ABOVE-NAMED DENTIST OR HIS/HER ASSOCIATES MAY CONSIDER NECESSARY.

UNDERSTAND THAT I AM RESPONSIBLE FOR **ALL** FEES REGARDLESS OF INSURANCE COVERAGE. I ALSO UNDERSTAND THAT AS TREATMENT PROGRESSES THE ABOVE FEES MAY HAVE TO BE ADJUSTED, BUT THAT I WILL BE INFORMED OF THESE ADJUSTMENTS AND HOW THEY WILL AFFECT MY PAYMENT PLAN. IN THE EVENT THAT MY PAYMENTS ARE NOT RECEIVED WITHIN 30 DAYS OF THEIR DUE DATE, I AGREE TO PAY ALL COSTS OF COLLECTIONS, INCLUDING, BUT NOT LIMITED TO, REASONABLE ATTORNEY'S FEES.

I CONFIRM THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE AND THAT ALL BLANK SPACES HAVE BEEN COMPLETED PRIOR TO MY SIGNING.

- HEREBY CONSENT TO THE PROPOSED DENTAL TREATMENT FOR THE PATIENT NAME LISTED ABOVE.
I have signed a disclosure and fully understand all the adverse risk (s) of the proposed treatment specific to the procedure listed above, which details in my chart listed on the Dental Department Invasive Consent & Treat Form & Patient Responsibilities Information Sheet. I have also been given professionally-recognized or evidence-based alternative treatment(s) to recommended therapy and risk (s).

_____ _____
SIGNATURE OF PATIENT OR PARENT (IF MINOR) / RELATIONSHIP TO PATIENT DATE

_____ _____
INTERPRETER (IF USED) DATE

_____ _____
SIGNATURE OF WITNESS/DENTAL ASSISTANT DATE

DENTIST CERTIFICATION:

I HEREBY CERTIFY THAT I HAVE EXPLAINED THE NATURE, PURPOSE, BENEFITS, RISKS OF, AND ALTERNATIVES (INCLUDING NO TREATMENT AND ATTENDANT RISKS), TO THE PROPOSED PROCEDURE(S). I HAVE OFFERED ANSWERS TO ANY QUESTIONS AND HAVE FULLY ANSWERED ALL SUCH QUESTIONS. I BELIEVE THAT THE TIENT/ PARENT/ GUARDIAN FULLY UNDERSTAND WHAT I HAVE EXPLAINED AND ANSWERED.

DENTIST'S SIGNATURE_____

PRINT NAME_____ DATE_____

Franklin Primary Health Center, Inc.
(FPHC)

PATIENT INFORMATION FORM

NAME		SOCIAL SEC #	ACCT #	
ADDRESS		VETEREN? (YES or NO)	EMPLOYER	
ADDRESS		**** IN AN EMERGENCY ****	RACE (List all that apply)	
CITY/ST/ZIP		EMERGENCY CONTACT NAME	SEX	MARITAL STATUS
HOME #	CELL #	EMERGENCY CONTACT PHONE #	DOB	

RESPONSIBLE PERSON			RELATION
ADDRESS			ACCT#
SOC SEC #	DOB		SEX

INS	PT ID	INS ID	CARRIER	EXPIRE
INS	PT ID	INS ID	CARRIER	EXPIRE
NAME PHARMACY OF CHOICE	PHONE #	ADDRESS		
E-MAIL ADDRESS				

HOUSEHOLD INFORMATION: INCOME INCLUDED: GROSS WAGES, SS INCOME, RAILROAD RETIREMENT, UNEMPLOYMENT COMP, STRIKE BENEFITS, WORKER'S COMP, PUBLIC ASSISTANCE, VETERANS' PAY, CHILD SUPPORT, ALIMONY, INSURANCE OR ANNUITY PAYMENTS, ETC. **WRITTEN DOCUMENTATION FOR ALL SOURCES OF INCOME, FOR ALL HOUSEHOLD MEMBERS MUST BE PROVIDED.**

NAME	DOB	AGE	SOURCE	AMOUNT	FREQUENCY
NAME	DOB	AGE	SOURCE	AMOUNT	FREQUENCY
NAME	DOB	AGE	SOURCE	AMOUNT	FREQUENCY
NAME	DOB	AGE	SOURCE	AMOUNT	FREQUENCY
NAME	DOB	AGE	SOURCE	AMOUNT	FREQUENCY
NAME	DOB	AGE	SOURCE	AMOUNT	FREQUENCY

IN ORDER TO ASSIST US IN PROVIDING YOU MEDICAL CARE, PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. WHAT LANGUAGE DO YOU PREFER TO USE: _____

2. DO YOU HAVE ANY CULTUAL OR RELIGIOUS BELIEFS THAT WOULD INFLUECENCE YOUR DECISION TO RECEIVE ANY ASPECTS OF HEALTHCARE SERVICES PROVIDED? _____

3. DO YOU CURRENTLY HAVE ADVANCE DIRECTIVES/LIVING WILL? **Yes** ☐ (Provide Copy) ☐ **No**

4. IN CASE OF AN EMERGENCY WHO WOULD YOU LIKE US TO DISCUSS YOUR MEDICAL INFORMATION WITH?

NAME: _____ RELATION: _____ NAME: _____ RELATION: _____

FRANKLIN'S PATIENT RIGHTS AND RESPONSIBILITIES, NOTICE OF PRIVACY PRACTICES AND GRIEVANCE POLICIES HAVE BEEN EXPLAINED TO ME AND I HAVE RECEIVED A COPY. I HAVE ALSO BEEN INFORMED THAT IF I HAVE A COMPLAINT OR EXPERIENCE ANY PROBLEMS DURING MY VISIT TO ASK FOR THE OFFICE MANAGER. INITIALS _____

ASSIGNMENT AND RELEASE: I, THE UNDERSIGNED CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. I CONSENT TO ANY SERVICES RENDERED TO ME OR MY DEPENDENTS UNDER DOCTOR'S ORDERS. I AUTHORIZE PAYMENT OF HEALTHCARE BENEFITS TO FPHC, INC. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES AND REFERENCE LAB FEES NOT PAID BY INSURANCE. I HEREBY AUTHORIZE FPHC, INC., TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT OF BENEFITS.

SIGNATURE: _____ DATE: _____

( ) PATIENT ( ) PARENT ( ) GUARDIAN

INTERVIEWER: _____ DATE: _____