Pre-Screen Questionnaire and Checklist

Name:_____ **Birthdate:**_____

1. Are you a NEW PATIENT or RECERTIFYING?

☐ NEW **(go to question 2)** ☐ RECERTIFYING —>

2. Do you have Medical Insurance, Medicaid or Medicare?

☐ NO ☐ YES

3. Do you have Dental Insurance?

☐ NO ☐ YES

4. Reason you are seeking services -

☐ MEDICAL: ☐ DENTAL ONLY

5. How did you learn about the Dental Clinic?

_____

If you have **questions**, you may contact the Dental Clinic at

540.536.1684

DCNSV DENTAL CLINIC

(Revised 3/2018)

Required Documents Checklist

<u>RECERTIFYING</u>: Please bring this application packet along with the required documents ANYTIME :

Monday or Friday : 8:30 AM - 4:30 PM

Tuesday or Thursday : 2:00 PM– 4:00 PM

<u>NEW PATIENTS</u>: Please bring this application packet along with the required documents during one of our screening times:

Designated appointment times

☐ Photo I.D.

☐ Social Security Card

☐ Proof of Residency

☐ IRS Form 1040 (if you file taxes)

☐ Proof of Income for the past 30 days

Can be any of the following:

- ☐ Paystubs for the past 30 days
- ☐ Social Security Retirement Current Award Letter
- ☐ Social Security Disability Original and Current Award Letter
- ☐ Proof of Pension Income
- ☐ Proof of Child Support and/or Alimony
- ☐ Letter from Employer (on company letterhead)
- ☐ Unemployment Benefits Award Letter
- ☐ Letter of Support
- ☐ 2 months of Bank Statements from all accounts
- ☐ Other:_____

☐ If **<u>NO</u>** income, how are you supporting yourself?*

*additional documents may be required

We cannot complete your application for services until all requested documents are received. If documents are not received within 30 days, you will need to re-apply.

Signature _____ Date _____

Patient Eligibility Form

(Revised 11/2015)

NAME: _____
Last First M.I.

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE: _____ **MESSAGE?** ☐ YES ☐ NO

EMER. CONTACT: _____ **PHONE:** _____

SEX: ☐ FEMALE ☐ MALE

LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ OTHER: _____

ETHNICITY: ☐ HISPANIC ☐ NON-HISPANIC

DATE OF BIRTH (mo/day/year):

SOCIAL SECURITY #:

Are you employed? ☐ **YES** ☐ **NO**

If YES, Where? _____

☐ Full-time ☐ Part-time

☐ Seasonal

Self-Employed? ☐ **YES** ☐ **NO**

Unemployed? ☐ **YES** ☐ **NO**

If YES, Why?

☐ Disabled ☐ Retired

☐ Homemaker ☐ Due to health

☐ Unable to find work

Race:

☐ White
☐ Black
☐ Hispanic
☐ Other:
_____

Marital Status:

☐ Married
☐ Single
☐ Divorced
☐ Widowed
☐ Cohabitate

Medical Insurance Status:

☐ APPLIED for Medicaid
☐ Medicaid
☐ VA Benefits
☐ Medicare
☐ Private Insurance
☐ NONE

If Homeless,

☐ Shelter
☐ Street
☐ Live w/ others

Active Workman's Compensation?

☐ YES ☐ NO

Drug Allergies: ☐ YES ☐ NO

If YES, List:

If you receive Social Security Benefits:

☐ SSI ☐ RETIREMENT ☐ DISABILITY

IMPORTANT: Proof of household income may be requested more than once per year.

Do you receive SNAP (food stamp) benefits? ☐ YES ☐ NO If yes, how much? $_____

# of People in the Household: _____

Name of Household Member	Age	Relationship to Patient	Income Source (Job, SS, etc.)	Gross Monthly Amount
Patient:		SELF		$
				$
				$
				$
				$
			Total:	$

PATIENT AGREEMENT/DISCLOSURE: I attest that this information is true and accurate. I have received a Patient Handbook and have read and understand it. I understand that in order to be a patient at the FMC, I must comply with all requirements. I agree that FMC will be my primary care physician. I understand that if I knowingly withhold information or provide false information, it may be grounds for permanent dismissal and I will be responsible for any bills incurred. I give the FMC staff permission to discuss and verify any and all information. I further give FMC permission to share this information with the Winchester Medical Center if I am referred there for services.

I do not have prescription drug coverage. I agree to allow the Free Medical Clinic to complete any patient assistance enrollment process on my behalf, which may include disclosure of personal and medical information. I also authorize the Free Medical Clinic to share medical and financial information with any and all pharmaceutical providers and RxPartnership for eligibility and audit purposes. I will immediately notify the Free Medical Clinic of any changes to my income, household size, or insurance status.

Signature: _____

Date: _____

For Staff Use ONLY:

	Date	Initials
Application :		
Consent Form:		
Photo ID		
Social Security Card:		
IRS Form:		
POI:		
LOS:		

Eligible for:

☐ All Services
☐ No PAP
☐ Dental Only

Expires: _____

Issued by: _____

Date: _____

☐ **NOT ELIGIBLE:** _____

Referred? ☐ WMC ☐ WATTS

Patient ID:

Patient Consent

Charges for Services Rendered (if applicable)

All charges for office services are due at the time of my visit to The Dental Clinic of Northern Shenandoah Valley, Inc. (DCNSV). I also understand that eligibility for the Dental Clinic of NSV. services do not include free services at Winchester Medical Center or Emergency Room. You must contact the financial department to make payment arrangements.

Signature Authorization

I authorize a staff representative of the Free Medical Clinic of Northern Shenandoah Valley, Inc. to sign forms on my behalf for the purpose of ordering medicine for me through medication assistance programs. This will help to expedite the ordering and reordering process and prevent delays in receiving medication provided under these programs. This authorization expires one year from the date below or until revoked by me.

Sharing/Disclosing Health Information/Acknowledgement of Receipt of Notice of Privacy Practices/HIPAA

I understand that different agencies provide different services/benefits and that each agency must have specific information in order to provide these services/benefits. By signing this form, I am allowing agencies to exchange certain information that will make it easier for them to effectively coordinate the services/benefits that I need for them to utilize my medical records for research and evaluation.

I, _____, hereby grant the Dental Clinic of Northern Shenandoah Valley, Inc. permission to exchange information including, but not limited to, medical records, mental health records, dental records/x-rays, financial information, benefits/services received, and medical research information.

I would like for this information to be shared between the Dental Clinic and the following agencies:

Winchester/Frederick County Health Dept., Winchester Medical Center, Referral Doctors and Dentists, Northwestern Community Services, Winchester Dept. of Social Services, Frederick Co. Dept. of Social Services and any other medical facility where prior treatment was received.

Treatment

I further authorize and consent to the practice's physicians, Nurse Practitioners, Physician Assistants, their assistants, and all other professional staff providing outpatient medical treatment, supplies, services, equipment and any other items related to my healthcare to me as to be determined necessary in their professional judgment. I have been informed of the nature and purpose of the treatment, and potential side effects thereof, as well as alternative treatment modalities, and approximate estimated duration of my healthcare, and that I am able to withdraw my consent for treatment either orally or in writing whether prior to or during the indicated treatment period.

Authorization and Acknowledgement

I (We), the undersigned, authorize treatment by the volunteer and staff providers (including students) at the Dental Clinic of Northern Shenandoah Valley, Inc. and I (we), the undersigned, understand and agree that all healthcare professionals rendering services at the Dental Clinic are exempt from liability. No person who is legally licensed and renders health care services within the limits of his/her license voluntarily and without compensation at the Dental Clinic (where no charges are made for any healthcare services) shall be liable for any civil damages for any act or omission resulting from the rendering of such services, unless such act or omission was the result of gross negligence or willful misconduct.

Notice of Statutory Consent

Section 332.1-45.1 Code Of Virginia. Code provides that whenever any medical personnel are directly exposed to patient's body fluids in a manner that may, according to the current guidelines of the CSC, transmit

Signature of Patient or Legal Representative	Witness	Date

(Revised 11/2015)

PATIENT INFORMATION / MEDICAL HISTORY

First Name: _____ **Middle Initial**: _____ **Last Name**: _____
Address: _____ **City, State, Zip**: _____
Home Phone: _____ **Work Phone**: _____ **Cell Phone**: _____
Birth Date: _____ **Sex:** □ Male □ Female **Marital Status**: □ Married □Single □Widowed □Divorced □Separated

Emergency Contact: _____ **Phone Number**: _____

If Patient is a Child:
Name of Parent or Guardian:_____ Relationship to the Child :_____
Address if different than above:_____
Phones: Home:_____ Work: _____ Cell: _____
Name of School /Employer : _____

1. Have you been under a physician care for the last 2 years? □ **Yes** □ **No**
   Name: _____ Address: _____ Phone: _____
2. Have you ever been hospitalized or had a major operation? □ **Yes** □ **No** If Yes, _____
3. Have you ever had a serious head or neck injury? □ **Yes** □ **No** If Yes, _____
4. Are you currently taking any medications? □ **Yes** □ **No**
   If Yes, please list: _____
5. Do you take, or have you taken, Phen-Fen or Redux? □ **Yes** □ **No** If Yes, _____
6. Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? □ **Yes** □ **No**
   If Yes, please list: _____
7. Are you allergic or ever reacted badly to any medications? □ **Yes** □ **No**
   If yes, please list:_____
8. Do you use controlled substances? □ **Yes** □ **No** If yes, please list:_____
9. Women: Are you…. Pregnant/ Trying to get pregnant? □ **Yes** □ **No** Nursing? □ **Yes** □ **No** Taking oral contraceptives?□ **Yes** □ **No**
10. Do you have or have you had any disease, or condition not listed below? □ **Yes** □ **No**
    If yes, please list: _____

Aids/HIV Positive	□ **Yes**	□ **No**	Excessive Thirst	□**Yes**	□**No**	Mitral Valve Prolapse	□**Yes**	□**No**
Alzheimer's Disease	□ **Yes**	□**No**	Fainting Spells/Dizziness	□**Yes**	□**No**	Osteoporosis	□**Yes**	□**No**
Anaphylaxis	□ **Yes**	□**No**	Frequent Cough	□**Yes**	□**No**	Pain in Jaw Joint	□**Yes**	□**No**
Anemia	□ **Yes**	□**No**	Frequent Diarrhea	□**Yes**	□**No**	Parathyroid Disease	□**Yes**	□**No**
Angina	□ **Yes**	□**No**	Frequent Headaches	□**Yes**	□**No**	Psychiatric Care	□**Yes**	□**No**
Arthritis/Gout	□ **Yes**	□**No**	Genital Herpes	□**Yes**	□**No**	Recent Weight Loss	□**Yes**	□**No**
Artificial Heart Valve	□ **Yes**	□**No**	Glaucoma	□**Yes**	□**No**	Renal Dialysis	□**Yes**	□**No**
Artificial Joint	□ **Yes**	□**No**	Hay Fever	□**Yes**	□**No**	Rheumatic Fever	□**Yes**	□**No**
Asthma	□ **Yes**	□**No**	Heart Attack/Failure	□**Yes**	□**No**	Rheumatism	□**Yes**	□**No**
Blood Disease	□ **Yes**	□**No**	Heart Murmur	□**Yes**	□**No**	Scarlet Fever	□**Yes**	□**No**
Blood Transfusion	□ **Yes**	□**No**	Heart Pacemaker	□**Yes**	□**No**	Shingles	□**Yes**	□**No**
Breathing Problems	□ **Yes**	□**No**	Heart Trouble/Disease	□**Yes**	□**No**	Sickle Cell Disease	□**Yes**	□**No**
Bruise Easily	□ **Yes**	□**No**	Hemophilia	□**Yes**	□**No**	Sinus Trouble	□**Yes**	□**No**
Cancer	□ **Yes**	□**No**	Hepatitis A	□**Yes**	□**No**	Spina Bifida	□**Yes**	□**No**
Chemotherapy/Radiation	□ **Yes**	□**No**	Hepatitis B or C	□**Yes**	□**No**	Stomach/Intestinal Disease	□**Yes**	□**No**
Chest Pains	□ **Yes**	□**No**	Herpes	□**Yes**	□**No**	Stroke	□**Yes**	□**No**
Cold Sores/Fever Blisters	□ **Yes**	□**No**	High Blood Pressure	□**Yes**	□**No**	Swelling of Limbs	□**Yes**	□**No**
Congenital Heart Disorder	□ **Yes**	□**No**	High Cholesterol	□**Yes**	□**No**	Thyroid Disease	□**Yes**	□**No**
Convulsions	□ **Yes**	□**No**	Hives or Rash	□**Yes**	□**No**	Tonsillitis	□**Yes**	□**No**
Cortisone Medicine	□ **Yes**	□**No**	Hypoglycemia	□**Yes**	□**No**	Tuberculosis	□**Yes**	□**No**
Diabetes	□ **Yes**	□**No**	Irregular Heartbeat	□**Yes**	□**No**	Tumors or Growths	□**Yes**	□**No**
Drug/Alcohol Addiction	□ **Yes**	□**No**	Kidney Problems	□**Yes**	□**No**	Ulcers	□**Yes**	□**No**
Easily Winded	□ **Yes**	□**No**	Leukemia	□**Yes**	□**No**	Venereal Disease	□**Yes**	□**No**
Emphysema	□**Yes**	□**No**	Liver Disease	□**Yes**	□**No**	Yellow Jaundice	□**Yes**	□**No**
Epilepsy or Seizures	□**Yes**	□**No**	Low Blood Pressure	□**Yes**	□**No**	Tobacco	□**Yes**	□**No**
Excessive Bleeding	□**Yes**	□**No**	Lung Disease	□**Yes**	□**No**			

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient/ Parent/ Guardian Signature: _____ Date: _____

DENTAL CLINIC OF NORTHERN SHENANDOAH VALLEY
CONSENT FOR TREATMENT/RELEASE/DEEMED CONSENT

FOR YOUR INFORMATION: Some of our dental providers volunteer their service without payment, whether at The Dental Clinic of Northern Shenandoah Valley 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 Winchester Medical Center Emergency Department or other appropriate facility of your choice.

We cannot sponsor patients for emergency room visits, 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 Winchester Medical Center of 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 director 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.

Patient Name: _____ Medicaid ID: _____

Patient/Guardian Signature: _____ Date: _____

Authorization Form for Use and Disclosure of Patient Information

Dental Clinic of Northern Shenandoah Valley, INC.
301 N. Cameron St, Suite 200
Winchester, VA 22601

Patient Name: _____ **Patient's Date of Birth:** _____/____/_____

Address: _____

Social Security Number: _____ - _____ - _____ **Medicaid ID**: _____

I authorize the release of information including the entire contents of dental record, including diagnosis, treatment details, appointment information and financial information.

This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

I understand that I have the right to revoke this Authorization, in writing, at any time by notifying this office. Such revocation will not affect actions taken by the requesting person prior to the date he or she received the written revocation. I also understand information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by this rule. I understand that my health care provider cannot condition treatment on whether I sign this Authorization.

This Authorization will remain in effect until terminated by me in writing and received by the dental clinic's Privacy Official at 301 N. Cameron St, Suite 200, Winchester, VA 22601.

Please call: **[ ]** My home number: _____

[ ] My work number: _____

[ ] My cell number: _____

Acknowledgement of Receipt of Privacy Practices Notice

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

Patient Signature: _____ **Date:** ____/____/_____

If Personal Representative:

Print Name: _____ Date: _____/_____/_____

Signature: _____ Relationship to Patient: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

[ ] Individual refused to sign

[ ] Communications barriers prohibited obtaining the acknowledgement

[ ] An emergency situation prevented us from obtaining acknowledgment

[ ] Other (Please Specify):

_____