NORTHEASTERN HEALTH CENTER
Dental Services

Northeastern Rural Health Clinics (NRHC) is a federally and state funded community health center. Due to funding sources we must report certain data on our patient population, including ethnicity (race), income information and resident status. No individual information or patient names are included in our data reporting. We thank you for your assistance in supplying this information. This information is kept strictly confidential and is used for data purposes only to help us continue to receive funding to serve you better.

HAVE YOU EVER BEEN SEEN AT ANY OF NORTHEASTERN'S CLINICAL SITES? ( ) YES ( ) NO

Patient Legal Name: _____
Last First Middle Nickname or Alias

Previous Names Used: _____

SSN#_____ DOB_____ Age_____ Sex ( ) Male ( ) Female

Twin? Yes or No If yes, Name of Twin:_____

Mailing Address:_____ City:_____ State: _____ Zip:_____

Physical Address if different:_____ City:_____ State:_____ Zip:_____

Phone #_____ Alternate #_____ Daytime#_____

Preferred Language (circle one) English Spanish Other:

Contact Preference: ( ) E-mail ( ) Phone Cell ( ) Phone Home ( ) Text

Special Instructions; See Comments:_____

Are you a Veteran? Yes No Marital Status: _____ Student: Yes No Part-time

Are you a Tobacco User? Yes No If Yes please circle one: Smoke Chew

Primary Physician:_____ Primary Dentist:_____

E-mail Address: _____

Place of Employment:_____ Part-time/Full-time/Seasonal

Emergency Contact:_____ Relationship_____ Phone#_____

If under 18 Birth Mother's Full Name:_____
Last First Middle Maiden Name

Support person/Care Giver:_____ Relationship_____ Phone_____

Role: ( ) Caregiver ( ) Emergency Contact ( ) Next of Kin

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Resident Status: This information is for data purposes only, please circle one:

Doubling Up Not Homeless Shelter Street

Transitional Unknown/Unreported

Migrant Worker ( ) None ( ) Migrant ( ) Not a Farm Worker ( ) Seasonal

Public Housing: ( ) No ( ) Other ( ) Public Housing ( ) Tenant Based Voucher

Ethnicity/Race (circle one**):** Asian Pacific Islander Alaskan Native

American Indian

Black or African American Native Hawaiian or Other Pacific Islander White Declined

Do you consider yourself Hispanic or Latino? Yes No Declined

Payment Information: Circle one and present documentation to Front Desk:

Self-pay Medi-Cal Insurance Medicare Sliding Fee Other

Name of Insurance:_____

Responsible Party Information: (**IF DIFFERENT FROM PATIENT**)

Legal Name: _____

Last First Middle

Mailing Address:_____ City:_____ State:_____ Zip:_____

Date of Birth:_____ SS#:_____ Marital Status:_____

Home Phone #:_____ Work # _____

Occupation:_____ Part-time/Full-time/Seasonal

Place of Employment: _____

Other Family Members related to Responsible Party (name and relationship)

_____

Please indicate your family income below (this information is to be used for data purposes only).

For a Family of (circle one):	**Circle Lower or Higher**	
1	Is your income Lower or Higher than →	$24,281/year
2	Is your income Lower or Higher than →	$32,921/year
3	Is your income Lower or Higher than →	$41,561/year
4	Is your income Lower or Higher than →	$50,201/year
5	Is your income Lower or Higher than →	$58,841/year
6	Is your income Lower or Higher than →	$67,841/year
7	Is your income Lower or Higher than →	$76,121/year
8	Is your income Lower or Higher than →	$84,761/year

****For more information, or if you have special circumstances, please ask to see our Patients Account Advisor****

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NORTHEASTERN RURAL HEALTH CLINIC
Dental Services

The below person(s) have my permission to speak to NRHC regarding my appointments and treatment.

Name:	Relationship:	Phone #:

_____ If a referral is required from my visit today or in the future; it is ok to leave a message on my Phone or with the above person(s) regarding appointment information.

Comment: _____

_____ It is okay to call and confirm appointments and leave a message on the machine or with the person who answers the phone.

Comment: _____

_____ It is okay to call and leave a message for me to call provider regarding my labs or test results.

Comment: _____

Patient or Legal Guardian Signature: _____

Date: _____

PAYMENT & TREATMENT AGREEMENT

By signing below I agree to and authorize the following:

- All the information I have provided on this "Patient Information Sheet" is true.
- I authorize the staff of Northeastern Rural Health Clinics (NRHC) to treat, test, and examine myself and any children/family member listed in the information I have provided.
- I authorize assignment of benefits (payments from a third party) for medical service to be paid to NRHC.
- I agree that I will receive a bill and pay the cost for services not covered by my health insurance or reimbursed by other funding programs.
- I understand use of any medical insurance or state funding means that NRHC may release information to the insurance company or the State of California about my medical diagnosis and care.
- I understand that NRHC uses outside laboratories for some of their tests.
- I understand that I may receive a bill from an outside laboratory if my insurance does not cover the cost of the test.

Patient or Legal Guardian's Signature: _____ Date: _____

Witness Signature and Title: _____

NORTHEASTERN RURAL HEALTH CLINICS
DENTAL SERVICES

Name: _____ Birthdate: _____

Please answer each question by checking **yes** or **no**. If in doubt, leave blank.

Why are you now seeking dental treatment? _____

	YES	NO
Are you in good health?		
Are you now under the care of a physician?		
If so, for what condition?		
Have you ever been hospitalized or had a serious illness?		
If **yes** please explain:		

	YES	NO
Have you ever had excessive bleeding, following an extraction or do cuts take longer to heal now than previously?		
Women - Are you pregnant? Give due date.		
Do you smoke? How much?		

Have you ever had any of the following:					
	YES	**NO**		**YES**	**NO**
Sinus problems			Stroke		
Headaches			Convulsions/epilepsy		
Tuberculosis			Emphysema		
Rheumatic fever			Heart murmur		
Chest pain/discomfort			Heart attack/trouble		
Shortness of breath			Heart disease		
High blood pressure			Congenital heart disease		
Artificial heart valve			Pacemaker		
Diabetes			Arthritis/rheumatism		
Artificial joints			Hepatitis		
Jaundice			Kidney disease		
Venereal disease			Bleeding tendency		
Blood transfusions			Radiation therapy		
Cancer			Bisphosphonate therapy		
HIV			Asthma		

Are you allergic to or have you ever had a reaction to any of the following:					
	YES	**NO**		**YES**	**NO**
Local anesthetics			Dyes or flavoring		
Barbiturates			Sleeping pills		
Sedatives			Penicillin/antibiotics		
Aspirin/codeine			Sulpha drugs		
Shellfish			Other		

Continued on back☞

Are you presently taking any of the following medications?					
	YES	**NO**		**YES**	**NO**
Antibiotics/sulpha			Blood thinners		
Blood pressure medication			Thyroid medicine		
Cortisone/steroids			Digitalis/heart medication		
Nitroglycerin			Aspirin		
Bisphosphonates			Inhalers		

Please list all medications and dosages you are currently taking (or within the past 2 years):

1.
2.
3.
4.

Is there any disease, condition or problem not listed above that you think we should know about or any activity your doctor says you cannot do?_____ **YES** _____ **NO**

Please explain:

Physician's name: Phone #

Have you ever had any serious trouble associated with any previous dental treatment?

_____ **YES** _____ **NO**

If so, please explain:

Date of last dental visit: Dental x-ray:

Which do you use?					
	YES	**NO**		**YES**	**NO**
Brush			Fluoride rinse		
How often?			Other		
Dental floss			Other		
How often?			Other		

Signature of patient or parent Date

Northeastern Rural Health Clinics

Northeastern Health Center
1850 Spring Ridge Drive
Susanville, CA 96130
530-251-5000

Westwood Family Practice
209 Birch Street
Westwood, CA 96137
530-256-3152

☐ Dental Services
Maryam Bahadori, DDS Dental Director
Charles Giddings, DDS
Katrina Ratliff, RDH
Ann Leve, RDH
530-251-5000 ext. 1441, 1442
Fax 257-7187

☐ Westwood Family Practice Dental
Gregory Long, DDS
530-256-3152

DENTAL MISSED APPOINTMENT POLICY:

In order to provide the best possible care for patients and the community that Northeastern Rural Health Clinic serves, it is necessary that you acknowledge our need to limit missed or cancelled short notice dental appointments to two (2) such occurrences within a 12 month period. A cancelled short notice event is defined as giving us less than 24 hour notice that you will not be able to use the scheduled time. After repeated no show or cancelled short notice appointments, future scheduled appointments will be at the discretion of your provider. You may be receiving a letter signed by your provider or the Dental Director outlining your future appointments. **In the event that it becomes necessary to enforce this agreement you will only be able to schedule appointments on a "walk in" or call as needed basis.**

FINANCIAL AGREEMENT:

Unless prior payment arrangements have been made *all payments* including co-pay and any deductible are due at the time of service. If you are unable to make a payment at the time of your visit, your appointment will be rescheduled.

If you have any questions please feel free to speak with any of our personnel at the front desk.

Patient: _____
Please Print

Signature: _____

Date: _____

Staff Initials: _____

I have been given a copy of the ***'Dental Materials Fact Sheet'*** to review. (Can be found posted on wall, or the front office staff can provide you with a copy)

_____ _____
Signature Date

Northeastern Rural Health Clinics
NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt:

By signing this form, you acknowledge either receipt of the "Notice of Privacy Practices" of Northeastern Rural Health Clinics, or that you have read a copy of the "Notice of Privacy Practices" of Northeastern Rural Health Clinics. Our "Notice of Privacy Practices" provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our "Notice of Privacy Practices" is subject to change. If we change our notice, you may obtain a copy of the revised notice from one or our Customer Service Representatives.

If you have any questions about our "Notice of Privacy Practices", please contact the Privacy Officer at (530) 251-5000.

___ I acknowledge receipt of a copy of the "Notice of Privacy Practices" of Northeastern Rural Health Clinics.

___ I acknowledge that I have read a copy of "Notice of Privacy Practices" of Northeastern Rural Health Clinics.

Date: _____ Time: _____ AM / PM

Signature: _____
(Patient or Legal Representative)

If signed by someone other than the patient, indicate relationship: _____

Print Name: _____
(Patient or Legal Representative)