ADULT PATIENT INFORMATION

Patient Name ____ Birth date____________ Race:_______ Sex: M _____ F_____
(for statistical purposes only)

Address ___________________________________ City _______________________ State _________ Zip ______________

Home Phone_________________________ Cell Phone _________________________ Email Address______________________

Social Security # ____________________________ Marital Status: Single_____ Married _____ Divorced_____ Widow_______

Employer Name_________________________________Address_____________________________________Phone____________

SPOUSE / PARENT / GUARDIAN INFORMATION (please circle one)

Name____ Birth date___________________

Address____ City________________________ State_________ Zip __________

Phone______________________________ Social Security #____

Employer____Phone______________________

Work Address______________________________________ City ________________________ State _________ Zip __________

EMERGENCY CONTACT

Name ____ Phone ______________________

PATIENT INSURANCE COVERAGE

Primary Insurance ____ Group/ID #_____________________________________

Secondary Insurance ____ Group/ID #___________________________________

DO YOU HAVE MEDICAID OR MEDICARE COVERAGE? Yes____ No_____ (If yes, please give # below)

Medicaid # ____Medicare #____

ARE YOU SELF-PAY? Yes________ No________(A sliding fee scale is required for all self-pay patients)

I hereby authorize the release of any medical/dental information necessary for the processing of insurance. I also authorize insurance benefits to be paid directly to Community Health Services. I understand that if my insurance does not pay, I am responsible for payment of services provided.

Signature____ Date___________________________

Revised 03/08

Provider #: __________

COMMUNITY HEALTH SERVICES

PATIENT RIGHTS AND RESPONSIBILITIES STATEMENT

Community Health Services encourages patients and their families to report concerns related to care, treatment, services, and patient safety issues. Community Health Services also ensures that the following rights and responsibilities are preserved for all patients.

PATIENT RIGHTS:

As a patient at Community Health Services you have the right to:

1. Understand and make use of these rights. If an interpreter is needed, the office will attempt to provide the assistance.
2. Equal treatment/care and accommodations that are available, or medically necessary regardless of race, creed, sex, or sources of payment.
3. Respectful care at all times and under all circumstances that allows you to maintain your dignity.
4. Privacy, both personal and informational, within the law.
5. Be assessed for pain.

PATIENT RESPONSIBILITIES:

1. Smoking is NOT allowed on CHS property.
2. You must bring the appropriate insurance card with you to each appointment.
3. A minimum payment is expected at the time of service.
4. When you come in for every appointment, please bring a list of ALL medications with you that you are currently taking. This includes prescriptions, over-the-counter medications, and herbal medication.
5. Due to the small size of exam rooms and waiting room, please limit the number of people accompanying you for your appointment to no more than two. If it is necessary for you to bring small children, please bring another adult to supervise them.
6. All refills on medications will be called to your pharmacy after 5:00 pm the next business day. Please do not call back to see if the refill has been called in.
7. If you cannot afford a medication which has been prescribed for you, let us know.
8. All calls (i.e. appointments, cancellations, refills, medical/dental records, etc.) should be called to the appropriate office phone number. Weekends, holidays, and after-hours, all calls will be transferred automatically to our answering service. In case of emergency when the office is closed, please go to the emergency room.
9. If your child is scheduled for a physical or immunizations you MUST bring a current immunization record with you.
10. Allow at least 30 days for completion of insurance forms, disability, transfer of treatment records, etc.
11. Please give a 24 hour notice when canceling or rescheduling appointments. Cancellations can be made 24 hours per day, but must be made prior to your appointment time.
12. An established patient who arrives more than 10 minutes late for his/her appointment is considered to be a “No Show” for their appointment, regardless of whether or not the patient is seen that day.
13. An established patient who is a “No Show” for 3 appointments without canceling within a 12 month time frame will be terminated from the practice. Refer to the No Show Policy for reinstatement guidelines.
14. An established patient is someone seen in one of our offices, by one of our providers.
15. If you have not been seen by one of our providers in three years you will be considered a new patient and must complete all required paperwork.

I, as a patient of COMMUNITY HEALTH SERVICES, agree to the above patient rights and responsibilities.

____ ________________

Patient Name Date

____ ________________

Signature of Patient or Guardian (if patient is a minor) Date

CHS

COMMUNITY HEALTH SERVICES
DENTAL CLINIC

MEDICAL HISTORY

Patient Name: ____ Date: __________________
Last First M.I.

Address: ____
Number and Street City State Zip

Home Phone: ______________________ Work Phone: ______________________

Date of Birth: ___________________ Sex: M F Height: ______________ Weight: __________

If you are completing this form for another person, what is your relationship to that person? ______________

Patient's Family Doctor: ____

Approximate Date of Last Medical Visit: __________ Approximate Date of Last Dental Visit: ___________

PLEASE ANSWER EACH QUESTION **CIRCLE**

1. Have you been under the care of a physician during the past 2 years? Yes No
2. Are you allergic to penicillin or any drugs or medicine? Yes No
   Please list: ____
3. Have you ever had any excessive bleeding requiring special treatment? Yes No
4. Circle any of the following which you have or have had:

Heart Disease	Tuberculosis (TB)	Anemia	Epilepsy	HIV
Cancer, Tumor	Rheumatic/Scarlet Fever	Arthritis	Asthma	Venereal Disease
Cardiac Pacemaker	Psychiatric Treatment	Hepatitis	Sinus Trouble	(VD) Type:
Heart Murmur	Cancer Treatment	Cough	Jaundice	___________
Diabetes	High Blood Pressure	Stroke		

5. Have you had any other medical conditions of which we should be aware? Yes No
   Please list: ____
6. (Women) Are you pregnant now? Yes No
7. (Women) Are you currently nursing? Yes No
8. Have you ever been diagnosed or treated for chemical dependency or alcoholism? Yes No
   If yes, when was your last usage and what was it? ______________________________
9. Have you taken any kind of medicine or drugs during the past year? Yes No

Please list all medications you are currently taking on the medication sheet.

Signature: ____ Date ______________

Signature, DDS: ____ Date ______________