**SIU Center for Family Medicine - Lincoln**
109 3rd Street, Lincoln, IL 62656-2604
Phone: 217.735.2317 Fax: 217.735.1872

Dental and Medical Services
Located at the Logan County Department of Public Health

*Federally Qualified Health Center (FQHC) - A collaboration with the Logan County Health Department and Abraham Lincoln Memorial Hospital*

# PATIENT REGISTRATION FOR DENTAL CLINIC

## Responsible Party: (if someone other than the patient)

First Name:_______________ Last Name:_______________ Middle Initial:___

Address:_______________ Address 2:_______________

City, State, Zip:_______________

Home Phone:_______________ Work Phone:_______________ Ext: _____ Cell Phone:_______________

Birth Date:____/____/______

## Patient Information:

First Name:_______________ Last Name:_______________ Middle Initial:___

Preferred Name: _______________

Is child a DCFS/foster care client? Yes_______ No_______

Address:_______________ Address 2:_______________

City, State, Zip:_______________

Home Phone:_______________ Work Phone:_______________ Ext:_____ Cell Phone:_______________

Birth Date:____/____/______

Sex: O Female O Male Marital Status: O Married O Single O Divorced O Separated O Widowed

E-mail: _______________ O I would like to receive email correspondences

Patient is: O Policy Holder (Medicaid/AllKids Card) O Self Pay (no Medicaid/AllKids Card)

Medicaid/AllKids ID #:_______________ Pref. Pharmacy: _______________

Date of last dental exam/cleaning: _______________

Additional Comments:

PLEASE COMPLETE BOTH SIDES

## MEDICAL HISTORY FOR DENTAL CLINIC

PATIENT NAME ______________________________ Birth Date ______________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions. Please circle the appropriate response.

Are you under a physician's care now? Yes No If yes, please explain: ______________________

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: ______________________

Have you ever had a serious head or neck injury? Yes No If yes, please explain: ______________________

Are you taking any medications, pills, or drugs? Yes No If yes, please explain: ______________________

Do you take, or have you taken, Phen-Fen or Redux? Yes No ______________________

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No ______________________

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Do you need to pre-medicate? Yes No If yes, please explain: ______________________

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain: ______________________________

Do you have, or have you had, any of the following?

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

Have you ever had any serious illness not listed above? Yes No If yes, please explain: ______________________

______________________________________________

Comments: ______________________________________________

______________________________________________

### STATEMENT OR CONSENT FOR HEALTH SERVICES

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. I hereby give my consent to all visits necessary for patient above to receive an oral evaluation, dental treatment, follow-up and maintenance treatment, and for the release of information of health conditions to official agencies and/or private doctors.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______________________________ DATE ______________

PATIENT/PARENT OR GUARDIAN NAME (Print) ______________________________

IN CASE OF EMERGENCY, PLEASE NOTIFY ______________________________ PHONE ______________

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# CLINIC POLICIES

- **24 Hour Cancellation:** All dental appointments require a 24 hour cancellation. A message can be left for the dental staff 24 hours a day, 7 days a week by calling the Logan County Department of Public Health at (217)735-2317 ext: 201. If no cancellation call is received 24 hours prior to the appointment time it will be considered a no-show.

- **Release from Dental Services:** A first time adult patient who no-shows for an appointment will not be scheduled for 6 months for any future appointments. For established patient families who have 3 no-shows or cancellations less than 24 hours prior to the appointment will not be scheduled for 1 year from the last no-show/canceled appointment date. This rule will apply for all members of the family. ***No appointments will be made with the dental clinic for services after a patient has been released.***

- **Confirming Appointments:** All patients must verbally confirm all scheduled appointments. If appointments are not verbally confirmed, then their appointment may be cancelled and the time will be given to another patient. If the appointment is given to another patient, they will be asked to reschedule.

- **Contact Information:** It is your responsibility to keep all contact information up to date with the dental clinic. ***If we are unable to contact you we reserve the right to cancel your appointment.***

IMPORTANT FOR ALL CLIENTS

- ***Patients are required to produce their current Medicaid/All Kids card at time of service. This is your form of payment. If a cash client, full payment is expected at time of service. We reserve the right to cancel your appointment if a current Medicaid/AllKids card or payment is not available at time of service.***

**Please Note:** In the event of non-payment by Medicaid, client served or guardian will be held responsible for the payment and will receive such statement/invoice.

**Initials:____________**

**I understand and agree to the above mentioned policies:**

**Patient Signature:**___________________________________ **Date:**

*MISSION STATEMENT: The SIU Center for Family Medicine cares for the health of you and your family as well as our community – with a dedicated and expert team serving all of your health needs in a compassionate and affordable environment.*

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## ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES FOR DENTAL CLINIC

I acknowledge that I have received a copy of this Dental Clinic's HIPAA Notice of Privacy Practices.

______________________________________

Patient Name (please print)

______________________________________ ________________________

Patient Signature Date

OR

______________________________________ ________________________

Signature of Personal Representative Date

Authority of Personal Representative to Sign for Patient (check one):

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other

_________________________________

**Please note:** It is your right to refuse to sign this Acknowledgement.

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***Dental Office Use Only***

I tried to obtain written Acknowledgement by the individual noted above of receipt of our Notice of Privacy Practices, but it could not be obtained because:

_____ An emergency prevented us from obtaining acknowledgement.

_____ A communication barrier prevented us from obtaining acknowledgement.

_____ The individual was unwilling to sign.

_____ Other

______________________________________ ________________________

Staff Member Signature Date

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