Southeast Community Health Systems
Dental Patient Registration (Age group, 5-11)

PATIENT INFORMATION

Last Name	First Name	MI	DOB	SS#

Street Address	City	State	Zip	County

CONTACT INFORMATION

Primary Phone Number		Secondary Phone Number	
	□ Home □ Cell □ Work		□ Home □ Cell □ Work
Do you need transportation? □**Yes** □ **No**		**Email:**	

PATIENT DEMOGRAPHICS

Primary Language Spoken
□ English □ Spanish □ Other_____

Would you like an interpreter?
□Yes □ No

Race (Check all that apply)
□ Black/African American □White
□Asian □ Unreported/Refused to Report
□ American Indian/Native Alaskan
□ Other Pacific Islander
□ Native Hawaiian
□ Other
_____

Ethnicity
□ Hispanic/Latino
□ Non-Hispanic/ Latino
□ Cuban
□ Puerto Rican
□ Another Hispanic, Latino or Spanish Origin
□ Unreported/Refused to Report

Place of Birth (City, State)

Gender Identity:
Do you think of yourself as:
□ Male
□ Female
□ Female-to-Male/Transgender Male/Trans Man
□ Male-to-Female/Transgender Female/Trans Woman
□ Genderqueer, neither exclusively male nor female

Sexual Orientation:
Do you think of yourself as: □ Straight or heterosexual
□ Lesbian, gay, or homosexual
□ Bisexual
□ Unknown
□ Other, please specify:
□ Refused to Report
_____

Marital Status
□ Single
□ Married
□ Divorced
□ Widowed
□ Separated
□ Life Partner

Student
□ Full-Time
□ Part-time
□ Not a Student, highest grade completed?
_____

Employment Status
□ Full-Time
□ Part Time
□ Not Employed
□ Retired
□ Disabled
□ Student
□ None

Employer **Phone No.**

Housing Status: □ Not Homeless □ Homeless
□ Other □ Doubling Up □ Public Housing □ Transitional
□ Street □ Homeless Shelter

Primary Care Provider _____
Pharmacy_____
Phone No. _____

Military Veteran?
□ Yes
□ No

Agriculture Status
□ Migrant Worker
□ Seasonal
□ Dependent of Migrant
□ Dependent of Seasonal
□ Not Agricultural Worker

GUARANTOR (Person To Be Billed, Check here if same as patient □)

Last Name	First Name	MI	DOB	SS#

Street Address	City	State	Zip	Home Phone	Cell Phone

EMERGENCY CONTACT (Someone outside of your home that we may contact in an emergency)

Last Name	First Name	Relationship

Street Address	City	State	Zip	Home Phone	Cell Phone

NEXT OF KIN (Check here if same as emergency contact □)

Last Name	First Name	Relationship

Street Address	City	State	Zip	Home Phone	Cell Phone

Southeast Community Health Systems

FAMILY INCOME INFORMATION

We request income on all patients for governmental reporting purposes.
If eligible for the Sliding Fee Scale, please complete separate Sliding Fee Application

Income Period: □ Weekly □ Bi-weekly □ Monthly □ Quarterly □ Annually □ Other _____
Gross Household Income: $_____ Number of individuals income supports: _____

INSURANCE INFORMATION

Please allow our staff to copy/scan your insurance card

PLAN # 1 Information

Insurance Company: _____
Member ID #:_____ Group #:_____
Patient's Relation to Subscriber: □ Self □ Child □ Parent □ Spouse □ Employer □ Other_____
**********If Patient is Subscriber (No need to complete the rest of this section)**********
First Name:_____ Middle Name:_____ Last Name:_____
Suffix:_____ Social Security Number:_____ Gender: □ Male □ Female
Date of birth (mm/dd/yyyy): _____
Street Address:_____ City:_____ State:_____
Zip:_____ Home Phone:_____ Mobile/Cell Phone:_____

PLAN # 2 Information

Insurance Company: _____
Member ID #:_____ Group #:_____
Patient's Relation to Subscriber: □ Self □ Child □ Parent □ Spouse □ Employer □ Other_____
**********If Patient is Subscriber (No need to complete the rest of this section)********** First Name:_____ Middle Name:_____ Last Name:_____ Suffix:_____ Social Security Number:_____
Gender: □ Male □ Female
Date of birth (mm/dd/yyyy): _____
Street Address: _____ City: _____ State: _____

INSURANCE ASSIGNMENT: I assign directly to Southeast Community Health Systems (SCHS) all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I hereby authorize SCHS to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions and for a copy for this statement and my signature to be kept on file and used in place of this original.

Patient/Guarantor Signature _____ Date: _____

Sliding Fee Scale Application

Date: / /

First Name: Middle Name: Last Name:

Household Size				
Name	Relationship	Date of Birth	Social Security Number	Income
	Head of Household			

Total Gross Income: $_____

NOTE: To comply with federal regulations, to give you a discount on our medical-dental services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income annually. Please bring yearly income tax return, last month's paycheck stubs, copies of your social security-food stamps award letters, or other supporting documents you may receive as proof of family income. Only the family size and annual gross income will be used to determine your eligibility and calculate your discount.

Sliding Fee Scale Discount Rates (Copy of Sliding Fee Scale available upon patient's request)

Medical Nominal Fee for Scale "A" - $30 for new patients
$25 for established patients

Dental Nominal Fee for Scale "A"- $40

All other office visits and/or procedures are discounted at the following percentages:
B-50% Discount
C-65% Discount
D-80% Discount
E- 0% Discount

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform Southeast Community Health Systems if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of Southeast Community Health Systems. I hereby acknowledge that I read the foregoing disclosure and understand it.

Last Name _____First Name _____

Signature of Patient or Guardian _____ Date _____

Southeast Community Health Systems

Patient Name: _____ **Birth date:** _____ **Date:**_____

GENERAL CONSENT FOR TREATMENT

1. I hereby authorize and consent to all necessary medical procedures needed for diagnosis and treatment for me and/or my dependents by Southeast Community Health Systems (SCHS).
2. I understand that no guarantee or assurance has been made as to the results that may be obtained.
3. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees of a cure have been made to me as a result of examinations or treatments by SCHS.
4. I give permission to release to my insurance company medical information necessary in the filing of lawful claims by SCHS' staff for services rendered by SCHS to me or my dependents.
5. I hereby authorize payment directly to SCHS of benefits relative to pending claims and/or Major Medical benefits otherwise payable to me, not to exceed SCHS' regular charges for this service.
6. I certify that the information that I have provided in applying for payments under Title XVII of the SSA Act is correct. I authorize any holder of medical or other information intermediaries, carriers, or any other insurer, any information needed for this or any related Medicare/Medicaid Claims. I request benefits be paid on my behalf.
7. I agree that a photocopy of this form is as valid as the original.
8. I agree and understand that the medical records are the property of SCHS; however, I can request a copy for a nominal fee at any time.
9. I certify that the information provided is true to the best of my knowledge.

Signature of Patient (or Guardian): _____ Date: _____

PATIENT RIGHTS

I have read and understand my rights and responsibilities as a patient of Southeast Community Health Systems and understand that if the quality of my care is compromised and if SCHS management staff or quality assurance committee cannot address it in a timely fashion, I have the option to report the healthcare compromise to the Joint Commission at (800) 994-6610, or email Complaint@jointcommission.org.

PATIENT RIGHTS Signature of Witness (when patient requires reading of rights): _____

PATIENT RESPONSIBILITY

1. I acknowledge that I am fully responsible for any and all expenses incurred at Southeast Community Health Systems for myself and/or dependents/family members.
2. I understand that all payments are due at the time of service.
3. I understand that all payments must be made towards any outstanding balance in addition to the payment for the current date of service rendered.

Signature of Patient (or Guardian): _____ Date: _____

ADVANCE DIRECTIVE ACKNOWLEDGEMENT

I understand that Southeast Community Health Systems does not honor Advanced Directives. In the event of a medical emergency during the clinic visit, first aid measures will be provided, 911 called and hospital transfer initiated.

Signature of Patient: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.
I wish to place the following restrictions on disclosure of my health information (Please list below or write N/A if no restrictions):

_____

Signature: _____ Date: _____

Relationship to patient if not signed by patient: _____

Southeast Community Health Systems

PLEASE GIVE THIS DOCUMENT TO THE DENTAL ASSISTANT

Although Dental Personnel primarily treat the areas in and around your mouth, it is important to note that your mouth is a part of a bigger system, your body. Health problems that you may have or medications that you may take have the potential for significant interactions with the dentistry you will be receiving. Please answer the following completely.

Patient's Name: _____ **Date of Birth:** ____ / ____ / _____ **Date of Service:** ____ / ____ /____
Physician's Name: _____ **Address:** _____
Physician's Office Phone: _____ **Date of Last Physical Exam:** _____

		Yes	No
1	Are you in good health?	☐	☐
2	Have there been any changes in your **general/overall** Health within the past year?	☐	☐
3	Are you now under the care of a physician?	☐	☐
4	Have you had a recent weight loss?	☐	☐
5	Have you ever been hospitalized for any surgical operation or serious illness? If yeas, please explain: _____ _____	☐	☐
6	Are you taking any medications (including over-the-counter or non-prescription medicine)? If yes, please list the medications: _____ _____		
7	Have you had any abnormal bleeding?	☐	☐
8	Do you bruise easily?	☐	☐
9	Have you ever required a blood transfusion?	☐	☐
10	Have you ever taken **Fen-Phen/Redux?**	☐	☐
11	Have you ever taken **Fosamax, Boniva, Actonel** or any cancer medications?	☐	☐
12	Have you ever taken **Viagra, Revatio, Cialis or Lavitra** within the last 24 hours?	☐	☐
13	Do you have any diseases, condition or problem (not listed below) that you think we should know about? If yes, please explain: _____ _____	☐	☐
14	Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
15	Do you use tobacco?	☐	☐
16	Do you or have you used controlled substances?	☐	☐
17	Are you wearing contact/corrective lenses?	☐	☐

WOMEN ONLY:

Are you pregnant or think you may become pregnant?	☐ Yes ☐ No
Are you taking birth control?	☐ Yes ☐ No
Are you nursing?	☐ Yes ☐ No

Please select any of the following that you have or have had:

☐ Rheumatic Heart Disease or Rheumatic Fever	☐ Hives or Skin Rash	☐ Anemia
☐ Scarlett Fever	☐ Fainting or dizzy spells	☐ Glaucoma
☐ Heart defect or heart murmur	☐ Diabetes	☐ Nervousness
☐ Heart trouble, heart attack, or angina	☐ HIV and/or AIDS	☐ Tonsillitis
☐ Chest Pain	☐ Thyroid problems	☐ Tumors
☐ Shortness of breath	☐ Allergies	☐ Mental Health Care
☐ Pacemaker	☐ Arthritis or Rheumatism	☐ Back problems
☐ Heart surgery	☐ Joint replacement or implant	☐ Chemical dependency
☐ High/Low Blood pressure	☐ Stomach ulcer	☐ Mitral Valve Prolapse
☐ Congenital heart problem	☐ Kidney trouble	☐ Cortisone treatment
☐ Swelling of feet, ankles, hands	☐ Tuberculosis	☐ Cold sores/fever blisters
☐ Hepatitis, jaundice or liver disease	☐ Persistent cough	☐ Hypoglycemia
☐ Stroke	☐ Cough that produces blood	☐ Eating Disorders
☐ Sinus trouble	☐ Chemotherapy (cancer, leukemia)	☐ Epilepsy or seizures
☐ Lung or breathing problems	☐ Asthma or hay fever	☐ Sexually transmitted disease

Please select any of the following that you have or have had:

☐ Local Anesthetics (i.e. Novocaine)	☐ Latex/Rubber	☐ Metals (Nickel, Mercury, etc.)
☐ Penicillin or Antibiotics	☐ Aspirin	☐ Barbiturates, Sedatives, or Sleeping Pills
☐ Sulfa Drugs	☐ Iodine	☐ Other, please list: _____

Appointment Confirmation & Cancellation Policy

We understand that unplanned issues can come up, and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be canceled at least 24 hours in advance. Our providers want to be available for your needs, and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. Although we have always had a cancelation policy, circumstances have caused us to enforce our revised policy.

Cancelation Policy

After the second missed appointment or no show, the patient will not be allowed to schedule an appointment with our office for 6 months. The patient can only have same day appointments if available.

Confirmation Policy

If a patient does not confirm their appointment within 24 hours of the appointment time, they will be taken off the schedule, and their appointment slot will be filled.

As of March 8, 2017, this policy is effective. Thank you for being a valued patient, and for your understanding, and cooperation as we institute this policy. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

_____	_____	____/____/____
Printed name	Signature	Date

Albany 225.306.2050
Greensburg 225.306.2070
Independence 225.306.2060
Kentwood 225.306.2100
Zachary 225.306.2000
Picardy 225.763.4990

The **Southeast Community Health Systems** Patient Portal provides an easy-to-use, secure, web-based method for patients to access portions of their medical records on-line. This is available from any computer (desktop, laptop or tablet) with Internet access. When you log into the **Southeast Community Health Systems** Patient Portal, you will be able to view information, including your medical conditions, medications, vital signs, lab results, allergies, and insurance policies.

Register for the Southeast Community Health Systems Patient Portal

Use this form to request a **Southeast Community Health Systems** Patient Portal account.
Once you have been registered for the **Southeast Community Health Systems** Patient Portal, you will receive an email from **Southeast Community Health Systems** with instructions to complete your Patient Portal registration.

Patient Registration Form

By completing this form, you are authorizing to set up a *Southeast Community Health Systems* Patient Portal Account.

Please complete using CAPITAL LETTERS with one character in each block.

FIRST NAME:	
LAST NAME:	
DATE OF BIRTH:	/ /
Last 4 Digits of SSN	
EMAIL ADDRESS:	
ZIP (Postal) Code #	-
Signature:	
Today's Date	/ /

☐Yes, I would like to be enrolled in the Southeast Community Health Systems Patient Portal.

Please allow 3 business days for your request to be processed.
A Southeast Community Health Systems representative may contact you to verify your information.

SOUTHEAST COMMUNITY Health Systems
Health, Vitality & Wellness

NICHQ Vanderbilt Assessment Scale---PARENT Informant

Today's Date: ____ /____/_____ Child's Name: _____ Date of Birth: ____ /____ /_____

Parent's Name: _____ Parent's Phone Number: _____-_____-_____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child, ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework.	0	1	2	3
2. Has difficulty keeping attention to what needs to be done.	0	1	2	3
3. Does not seem to listen when spoken to directly.	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand).	0	1	2	3
5. Has difficulty organizing tasks and activities.	0	1	2	3
6. Avoids, dislikes or does not want to start tasks that require ongoing mental effort.	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books).	0	1	2	3
8. Is easily distracted by noises or other stimuli.	0	1	2	3
9. Is forgetful in daily activities.	0	1	2	3
10. Fidgets with hands or feet or squirms in seat.	0	1	2	3
11. Leaves seat when remaining seated is expected.	0	1	2	3
12. Runs about or climbs to much when remaining seated is expected.	0	1	2	3
13. Has difficulty playing or beginning quiet play activities.	0	1	2	3
14. Is "on the go' or often acts as if "driven by a motor".	0	1	2	3
15. Talks to much.	0	1	2	3
16. Blurts out answers before questions have been completed.	0	1	2	3
17. Has difficulty waiting his or her turn.	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities.	0	1	2	3
19. Argues with adults.	0	1	2	3
20. Loses temper.	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules.	0	1	2	3
22. Deliberately annoys people.	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors.	0	1	2	3
24. Is touchy or easily annoyed by others.	0	1	2	3
25. Is angry or resentful.	0	1	2	3
26. Is spiteful and want to get even.	0	1	2	3
27. Bullies, threatens or intimidates others.	0	1	2	3
28. Starts physical fights.	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie., "cons" others).	0	1	2	3
30. Is truant from school (skips school) without permission.	0	1	2	3
31. Is physically cruel to people.	0	1	2	3
32. Has stolen things that have value.	0	1	2	3
33. Deliberately destroys others' property.	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun).	0	1	2	3
35. Is physically cruel to animals.	0	1	2	3
36. Has deliberately set fires to cause damage.	0	1	2	3
37. Has broken into someone else's home, business or car.	0	1	2	3

SOUTHEAST COMMUNITY Health Systems
Health, Vitality & Wellness

NICHQ Vanderbilt Assessment Scale---PARENT Informant, *continue*

Today's Date: ____ /____/_____ Child's Name: _____ Date of Birth: ____ /____ /_____

Parent's Name: _____ Parent's Phone Number: _____-_____-_____

Symptoms	Never	Occasionally	Often	Very Often
38. Has stayed out a night without permission.	0	1	2	3
39. Has run away from home overnight.	0	1	2	3
40. Has forced someone into sexual activity.	0	1	2	3
41. Is fearful, anxious or worried.	0	1	2	3
42. Is afraid to try new things for fear of making mistakes.	0	1	2	3
43. Feels worthless or inferior.	0	1	2	3
44. Blames self for problems, feels guilty.	0	1	2	3
45. Feels lonely, unwanted or unloved; complains that "no one loves him or her".	0	1	2	3
46. Is sad, unhappy or depressed.	0	1	2	3
47. Is self-conscious or easily embarrassed.	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a problem	Problematic
48. Overall school performance.	1	2	3	4	5
49. Reading.	1	2	3	4	5
50. Writing.	1	2	3	4	5
51. Mathematics.	1	2	3	4	5
52. Relationship with parents.	1	2	3	4	5
53. Relationship with siblings.	1	2	3	4	5
54. Relationship with peers.	1	2	3	4	5
55. Participation in organized activities (ie., teams).	1	2	3	4	5

Comments: _____
_____
_____
_____
_____

For Office Use Only

Total number of questions scored 2 or 3 in questions 1 – 9: _____

Total number of questions scored 2 or 3 in questions 10 – 18: _____

Total Symptom Score for questions 1 – 18: _____

Total number of questions scored 2 or 3 in questions 19 – 26: _____

Total number of questions scored 2 or 3 in questions 27 – 40: _____

Total number of questions scored 2 or 3 in questions 41 – 47: _____

Total number of questions scored 2 or 3 in questions 48 – 55: _____

Average Performance Score: _____

Parent/Legal Guardian Authorization Form

(PLEASE PRINT)

I _____ authorize _____
(Parent/Guardian Name) **(Family/Friend Name)**

who is the _____, to bring my child/children in to see the Physician/Dentist/Social Workers/ Counselors/Psychologist/Nurse Practitioner at Southeast Community Health Systems in my absence.

Name of Child/Children	**Date of Birth**
1.	
2.	
3.	
4.	
5.	

_____ _____/_____/_____
Parent/Guardian Signature **Date**