DENTAL REGISTRATION FORM

NAME: First: _____ Middle: _____ Last: _____

Mailing Address: _____

Street Address (If Different from Mailing): _____

Phones: Home: _____ Cell: _____ Work: _____

Which phone do you prefer we use to contact you? Home: ____ Cell ____ Work _____.

Do you prefer to be called in the AM ____ Afternoon ____ Evening____?

What is your Email address: _____

(By providing you will be sent an email to join our patient portal.)

Date of Birth: _____ Sex: _____ Social Security Number _____

Responsible Party (If not you): _____Their Birthday: _____ Relationship: _____

Responsible Parties Address & Phone: _____

Emergency Contact: _____Phone: _____

Relationship to emergency contact: Spouse ___ Son/Daughter ___ Parent ___ Friend ___ Other ___ Please Specify _____

Marital Status: Married ___ Single ___ Divorced ___ Widow/Widower ___ Separated ___ Significant Other ___

If married, name of spouse: _____ Closest Relative: _____ Phone ( ) _____

If not ENGLISH, what is your preferred language: _____

Race: _____ Ethnicity: _____

Employer Address: _____

What pharmacy do you use? _____

PLEASE ANSWER ALL THE FOLLOWING QUESTIONS. THEY ARE KEPT CONFIDENTAL AND USED FOR MANDATORY GRANT REPORTING:

Do you have city water at your home: yes ___ no ___ Do you live in public housing: yes ___ no ___

Are you a: Veteran _____ Seasonal Worker _____ Migrant Worker _____ Homeless _____

How many people are in your home, including you? _____

What is your TOTAL household income, either: Annual _____ Monthly _____ Bi-weekly _____ Weekly _____

(Include child support, disability, social security, welfare, pension, etc. for each member)

_____ Initial here if you are above 201 percent of the posted sliding scale, not eligible for sliding fee discounts & <u>DO NOT</u> want to disclose your income.

Chief Dental Complaint _____

_____

1. Do you/your child have any pain in your jaws or face? ..... Yes No
2. Do you/your child have a toothache? ..... Yes No
3. Are you receiving any topical fluoride application? ..... Yes No
4. Have you had any serious trouble with any previous dental treatment? ..... Yes No
5. Have you ever been told to take premedication prior to a dental visit? ..... Yes No
6. Do you have dry mouth? ..... Yes No
7. Do you have halitosis (bad breath)? ..... Yes No
8. Do you use any prescription dental products? ..... Yes No
9. Are you using any whitening products? ..... Yes No
10. Do you use a sonic or power toothbrush? ..... Yes No
11. Do you have sensitive teeth? ..... Yes No
12. Do you wear any dental appliances? ..... Yes No
    If so, what appliance and where? _____
13. How often do you brush? _____
14. How often do you floss? _____
15. When was your last dental visit? _____
16. What was your last dental visit for? _____
17. When was the last time you had your teeth cleaned? _____
18. When was the last time you had dental x-rays? _____

1. Name of physician? _____ Yes No
2. Have you been hospitalized in the past 5 years? ..... Yes No
3. Are you taking any medications? .....
   If so, please list medicines _____
4. Do you have any of the following:
   a. Cardiovascular disease (heart trouble, heart attack, angina, high blood pressure, stroke, stints, or Yes No
      cardiac pacemaker)? ..... Yes No
   b. Are you taking any blood thinners including aspirin? ..... Yes No
   c. Do you take nitroglycerin? ..... Yes No
      If so, do you carry it with you? ..... Yes No
   d. Heart murmur, rheumatic heart disease, damaged or artificial heart valves? .....
   e. Seasonal allergies Sinus Trouble Asthma (Circle Those that Apply) Yes No
   f. Fainting spells or seizures? ..... Yes No
   g. Epilepsy? ..... Yes No
   h. Diabetes? ..... Yes No
   i. Hepatitis? What type? _____ ..... Yes No
   j. AIDS or HIV infection? ..... Yes No
   k. Thyroid problems? ..... Yes No
   l. Respiratory problems? ..... Yes No
   m. Arthritis? What type? _____ ..... Yes No
      Are you taking bisphosphonates such as: Fosamax, Boniva, Actonel, or Reclast or other? ..... Yes No
   n. Stomach problems? ..... Yes No
   o. Kidney problems? ..... Yes No
   p. Tuberculosis? ..... Yes No
   q. Problems with mental health: (If yes circle one below) .....
      Anxiety Depression ADHD or ADD Schizophrenia Autism Other _____ Yes No
   r. Cancer? ..... Yes No
      Are you taking Chemotherapy? ..... Yes No
      Are you taking radiation? ..... Yes No
   s. Do you have problems with your immune system? ..... Yes No
      Lupus? ..... Yes No
   t. Have you had any artificial hip or knee replacements? ..... Yes No
   u. Have you ever had endocarditis? ..... Yes No
   v. Abnormal bleeding? ..... Yes No
      Anemia? .....
5. Are you allergic to or have you had a reaction to: Yes No
   a. Local anesthetics? ..... Yes No
   b. Penicillin or other antibiotics? ..... Yes No
   c. Sulfa drugs? ..... Yes No
   d. Codeine or other narcotics? ..... Yes No
   e. Latex? ..... Yes No
   f. Other? _____ ..... Yes No
6. Have you had any condition or problem not listed above that you think I should know about? ..... Yes No
7. Taking birth control pills? ..... Yes No
8. Are you pregnant? ..... Yes No
9. Are you nursing? ..... Yes No
10. Do you have a history of alcohol or substance abuse? ..... Yes No
    If yes, please list _____
11. If you use nicotine, what form do you use? _____

WELCOME TO CLOVER FORK CLINIC

Clover Fork Clinic is a patient-centered, family-focused, federally qualified health center look-alike dedicated to the health and wellness of the patients and communities we serve.

OUR LOCATIONS
****Walk-ins Accepted****

Clover Fork Clinic of Evarts, KY
101 Chad Street – P.O. Box 39
Evarts, KY 40828
Phone: (606) 837-2108
Fax: (606) 837-2111
Hours
M-F: 8:00 am – 4:30 pm Front Desk Closes

Clover Fork Clinic of Harlan, KY
209 East Mound Street
Harlan, KY 40831
Phone: (606) 573-1975
Fax: (606) 837-2111
Hours
Monday: 8:30 am – 7:00 pm
Tuesday – Friday 8:30 am – 5:00 pm

Pharmacy - Evarts
M, W, T, F: 9:00 am – 5:30 pm
Tues. 10:00 am – 5:30 pm
Dental - Evarts
M-F: 8:00 am – 4:30 pm

Be Prepared for your Visit

✓Current Insurance Card ✓Photo ID ✓Bring ALL of the medications you are currently taking
✓*Payment – We accept cash, check, and credit/debit* ✓Up-to-date blood pressure or glucose readings
✓Verify your name, address, phone number(s), Insurance carrier(s) and preferred pharmacy
✓Any changes such as marital status, employer, or authorized and/or emergency contacts

****See our Financial Policy on the back side of this letter. It also contains our sliding fee discounts.****

AFTER HOURS: Clover Fork Clinic's afterhours nurse line provides access to the clinics Registered Nurse 24 hours, 7 days a week. The nurse can be contacted after hours at (606) 505-5179.

WEB ACCESS: The Clover Fork Clinic will make web access available to all patients. Our electronic communication portal allows patients to access and manage their medical record, request appointments, address billing issues, order refills, and communicate securely with their provider. Please see our receptionist to sign up.

Please see reception if you need a wheelchair or other assistance with a disability.

Qualified sign language interpreters are available upon request.

CLOVER FORK CLINIC

Serving families across Appalachia since 1970

Financial Policy

We are committed to providing you with the best possible medical care. If you have special needs; we are here to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning your payment for professions services.

1. Our office accepts most insurance plans (Medicare, Medicaid. And commercial insurance). It is your responsibility to:
    a. Bring your insurance card at every visit.
    b. Be prepared to pay your copayment or minimal fee. Payment can be made by cash, check, or credit card.
    c. You will be billed for medical care not covered under your insurance company.
2. If you have insurance in which we do not participate, our office is happy to file the claim upon request; however, you are expected to pay the minimal payment.
3. If you are unable to pay for necessary medical care, you may be eligible for financial assistance and receive a discount based on your household income and family size. It is the patient's responsibility to bring all required documentation before we can process a sliding fee application. Proper proof of income is the most current tax return, the two most recent pay stubs, most recent statement from social services, or a letter from the caregiver with explicit amounts of money that are given on a monthly basis. Sliding scale discounts will be based on the most recent Federal Poverty Index (FPI) guidelines. Patients lacking proper proof of income at the time of their visit must provide this documentation within two weeks. The parent, guardian of a minor is responsible for the minimal payment, if any, at the time of service.
4. If you have questions about your insurance or would like to set up a payment plan, we are happy to help.

CLOVER FORK MEDICAL CLINIC

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. ***Please review it carefully.***

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- Get an electronic or paper copy of your medical record
  - ~ You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us ow to do this.
  - ~ We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Ask us to correct your medical record
  - ~ You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
  - ~ We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Request confidential communications
  - ~ You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
  - ~ We will say "yes" to all reasonable requests.
- Ask us to limit what we use or share
  - ~ You can ask us **not** to use or share certain health information for treatment, payment, or our operations. *We are not required to agree to your request, and we may say "no" if it would affect your care.*
  - ~ If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- Get a list of those with whom we've shared information
  - ~ You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
  - ~ We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- Get a copy of this privacy notice
  - ~ You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- Choose someone to act for you
  - ~ If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
  - ~ We will make sure the person has this authority and can act for you before we take any action.
- File a complaint if you feel your rights are violated
  - ~ You can complain if you feel we have violated your rights by contacting us using the information on this page.
  - ~ You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
  - ~ We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

- In these cases, you have both the right and choice to tell us to:
  - ~ Share information with your family, close friends, or others involved in your care
  - ~ Share information in a disaster relief situation
  - ~ Include your information in a hospital directory
  - ~ Contact you for fund-raising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- In these cases we never share your information unless you give us written permission:
  - ~ Marketing purposes
  - ~ Sale of your information
  - ~ Most sharing of psychotherapy notes

- In the case of fund-raising
  - ~ We may contact you for fund-raising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways.

- Treat You
  - ~ We can use your health information and share it with other professionals who are treating you.
    Example: A doctor treating you for an injury asks another doctor about your overall health condition.
- Run our organization
  - ~ We can use and share your health information to run our practice, improve your care, and contact you when necessary.
    Example: We use health information about you to manage your treatment and services.
- Bill for your services
  - ~ We can use and share your health information to bill and get payment from health plans or other entities.
    Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information? We are allowed or required to share your information in other ways - usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

- Help with public health and safety issues
  - ~ We can share health information about you for certain situations such as:
    - Preventing disease
    - Helping with product recalls
    - Reporting adverse reactions to medications
    - Reporting suspected abuse, neglect, or domestic violence
    - Preventing or reducing a serious threat to anyone's health or safety.
- Do research
  - ~ We can use or share your information for health research.
- Comply with the law
  - ~ We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- Respond to organ and tissue donation requests
  - ~ We can share health information about you with organ procurement organizations.
- Work with a medical examiner or funeral director
  - ~ We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- Address workers' compensation, law enforcement, and other government requests
  - ~ We can use or share health information about you:
    - For workers' compensation claims
    - For law enforcement purposes or with a law enforcement official
    - With health oversight agencies for activities authorized by law
    - For special government functions such as military, national security, and presidential protective services
- Respond to lawsuits and legal actions
  - ~ We can share health information about you in response to a court or administrative order, or in response to a subpoena

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice We can change the terms of this notice, and the changes will apply to all information we have about you.
The new notice will be available upon request, in our office, and on our web site. **EFFECTIVE DATE: MARCH 26, 2013**

This Notice of Privacy Practices applies to CLOVER FORK CLINIC OF EVARTS AND CLOVER FORK CLINIC OF HARLAN

Privacy Officer L. Mefford, Director of Medical Records 606/837-2108 Ext. 113 E-Mail: lindam@cloverforkclinic.org

GENERAL CONSENT TO TREAT:

_____ Initial Here

I voluntarily authorize and consent to the medical care, treatment, and diagnostic tests that Clover Fork Clinic (CFC) believes are necessary. I understand that by signing this form, I am giving permission to the doctors, nurses, physician assistants, and other health care providers in this medical office to provide treatment as long as I am a patient in this office, or until I withdraw my consent. I am aware that the practice of medicine is not an exact science and that no guarantee can be made concerning the results of treatment. I may receive all medical care provided according to generally and currently accepted standards of medical care.

_____ Initial Here

I have the right to revoke or change this consent to treat in writing.

CONSENT TO RELEASE AND OBTAIN INFORMATION:

_____ Initial Here

In agreement with federal and state law, I agree to allow CFC to deliver the necessary care in order to provide continuity of care and treatment. CFC and/or the patient's provider may obtain from any source and examine and use, or discuss and disclose, my medical record and information to treating hospital personnel and agents, other health care providers, medical records auditors, professional committees, care evaluators and governmental agencies. We may make your protected information available electronically through an information exchange service to other health care providers that request your information. Participation in information exchange services also lets us see their information about you. This information can include, but is not limited to: medical history, examinations, diagnoses, treatments, any psychiatric, drug and alcohol abuse or genetic testing information, or HIV or AIDS information. This consent to release and obtain information is valid until revoked. I understand that I may revoke the consent in writing at any time except with regard to disclosures that have already been made in reliance on such consent.

IN ABSENCE OF THE PATIENT: the following people are authorized to have access to his/her medical information. (You may name a spouse, children, or other relatives, friends, adult care providers or others).

Name: _____ Relationships: _____

Name: _____ Relationships: _____

If no other person, besides the patient is authorized please circle: NONE

ELECTRONIC PRESCRIPTIONS (E-PRESCRIBING):

_____ Initial Here

I voluntarily authorize CFC to allow E-Prescribing for any and all prescription, which allows healthcare providers to electronically transmit prescriptions to the Pharmacy of my choice; review pharmacy benefit information and medication dispense history as long as I am a patient in this office, or until I withdraw my consent.

PERSONAL INFORMATION:

_____ Initial Here

I certify the information supplied for my registration to be current, complete, and accurate to the best of my knowledge. I understand by not supplying CFC with all possible insurance coverage could result in a delay of treatment, referrals, diagnostic testing, and create an account balance that I would be solely responsible for. I also authorize the release of any medical or other information necessary to process my insurance claim. I authorize payment of medical/dental benefits to Clover Fork Clinic.

WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF CLOVER FORK CLINIC'S NOTICE OF PRIVACY PRACTICES:

_____ Initial Here

I acknowledge receiving CFC's Notice of Privacy Practices (NPP). The Notice explains how CFC may use and disclose your protected health information for treatment, Payment and health care operations purpose. "Protected health information" means your personal health information found in your medical and billing records.

_____ Initial Here

I have read this form or this form has been read to me in a language that I understand and I have had an opportunity to ask questions about it.

YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT CFC'S PRIVACY OFFICER. CONTACT INFORMATION IS LOCATED IN THE NOTICE.

PLEASE PRINT YOUR NAME: _____

SIGNATURE OF PATIENT: _____ DATE: _____

WITNESSED BY CFC STAFF: _____ DATE: _____

WHAT YOU SHOULD KNOW ABOUT HIV & AIDS

WHAT IS AIDS?

AIDS is the Acquired Immune Deficiency Syndrome – a serious illness that makes the body unable to fight infection. A person with AIDS is susceptible to certain infections and cancers. When a person with AIDS cannot fight off infections, this person becomes ill. These infections can eventually kill a person with AIDS.

WHAT CAUSES AIDS?

The human immunodeficiency virus (HIV) causes AIDS. Early diagnosis of HIV infection is important! If you have been told that you have HIV, you should get prompt medical treatment. In many cases, early treatment can enhance a person's ability to remain healthy as long as possible. Your doctor will help you determine the best treatment for you. Free or reduced cost anonymous and confidential testing with counseling is available at most local health departments in Kentucky. After being infected with HIV, it takes between two weeks to six months before the test can detect antibodies to the virus.

HOW IS THE HIV VIRUS SPREAD?

- Sexual contact (oral, anal, or vaginal intercourse) with an infected person when blood, pre-ejaculation fluid, semen or cervical/vaginal secretions are exchanged.
- Sharing syringes, needles, cotton, cookers and other drug injecting equipment with someone who is infected.
- Receiving contaminated blood or blood products (very unlikely now because blood used in transfusions has been tested for HIV antibodies since March 1985).
- An infected mother passing HIV to her unborn child before or during childbirth, and through breast feeding.
- Receipt of transplant, tissue/organs, or artificial insemination from an infected donor.
- Needle stick or other sharps injury in a health care setting involving an infected person. Infections can sometimes be prevented by taking post-exposure prophylaxis anti-retroviral drugs. Strict adherence to universal precautions is the best way to prevent exposures.

YOU CANNOT GET HIV THROUGH CASUAL CONTACT SUCH AS:

- Sharing food, utensils, or plates
- Touching someone who is infected with HIV
- Hugging or shaking hands
- Donating blood or plasma (this has NEVER been a risk for contracting HIV)
- Using public rest rooms
- Being bitten by mosquitoes or other insects
- Using tanning beds (always clean before and after use)

HOW CAN I PREVENT HIV/AIDS?

- Do not share needles or other drug paraphernalia.
- Do not have sexual intercourse except with a monogamous partner whom you know is not infected and who is not sharing needles. If you choose to have sex with anyone else, use latex condoms (rubbers), female condoms or dental dams, and water based lubricants every time you have sex.
- Educate yourself and others about HIV infection and AIDS.

WOMEN AND HIV/AIDS

For females with HIV/AIDS in Kentucky, heterosexual exposure and injection drug use are the most common modes of transmission of HIV. HIV can be spread through body fluids (i.e., blood, semen, vaginal secretions, and breast milk).

All pregnant women should have blood tests to check for HIV infection.

- Mothers can pass HIV infection to their babies during pregnancy, labor and delivery, and by the child ingesting infected breast milk.
- Without treatment, about 25% (1 out of 4) of the babies born to HIV infected women will get HIV.
- Medical treatment for the HIV infected woman during pregnancy, labor, and delivery can reduce the chance of the baby getting HIV from its mother to less than 2% (less than 2 out of 100).
- An HIV infected mother should not breastfeed her newborn baby.

IS TREATMENT AVAILABLE IF I ALREADY HAVE HIV/AIDS?

After being infected with HIV, it takes between two weeks to six months before the test can detect the HIV virus. **Early diagnosis of HIV infection is important!** Free anonymous and confidential testing and counseling is available at every Health Department in Kentucky. Testing requires drawing a small tube of blood from a vein in your arm. If you have HIV, you should get prompt medical treatment. In many cases, early treatment can enhance a person's ability to remain healthy as long as possible. Your doctor will help you determine the best treatment.

GETTING TESTED FOR HIV:

If you have never been tested for HIV, you should be tested at least once. Centers for Disease Control and Prevention (CDC) recommends being **tested at least once a year if you do things that can transmit HIV.** These include:

- Injecting drugs or steroids with used injection equipment
- Having sex with someone who has HIV or any sexually transmitted disease (STD)
- Having more than one sex partner since your last HIV test
- Having a sex partner who has had other sex partners since your last HIV test
- Having sex for money or drugs (prostitution- male or female)
- Having unprotected sex or sex with someone who has had unprotected sex
- Having sex with injecting drug user(s)
- Having had a blood transfusion between 1978 and 1985
- Pregnant women or women desiring to become pregnant

WHAT IS UNSAFE SEX?

- Vaginal, anal, or oral sex without using a condom or dental dam

Remember: You can't tell whether or not someone has HIV just by looking at them!

- Sharing sex toys
- Contact with HIV infected blood, semen, or vaginal fluid

WHAT IS "SAFER" SEX?

- Abstinence (not having sex of any kind)
- Sex only with a person who does not have HIV, does not practice unsafe sex, or inject drugs
- Using either a male or female condom or dental dam (for oral sex)

How to use a latex condom:

1. Use a new latex condom every time you have sex.
2. The condom should be rolled onto the erect (hard) penis, pinching ½ inch at the tip of the condom to hold the ejaculation (semen) fluid. Air bubbles should be smoothed out.
3. Use plenty of WATER-BASED lubricants such as K-Y Jelly, including a drop or two inside the condom, before and during intercourse. **DO NOT USE** oil-based lubricants such as petroleum jelly, mineral oil, vegetable oil, Crisco, or cold cream.
4. After ejaculating, withdraw the penis holding the condom at the base so it will not slip off.
5. Throw away the used condom into a garbage can and wash hands.

IF YOU NEED MORE INFORMATION CALL:

Kentucky HIV/AIDS Program 502-564-6539

The National AIDS Hotline 1-800-342-AIDS

This agency provides quality services to all patients, regardless of HIV status.

Your local health department's HIV/AIDS Coordinator

CHFS- EPI
6/13