Smiles on Wheels
Phone: 517-740-7422 Fax: 517-315-4918

Patient Information

Patient Name: _____ Date:_____
Last First MI
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____
Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Email address_____

Address: _____
Street Apartment #
_____
City State Zip Code
Emergency Contact #_____

I give consent for Smiles on Wheels to take and use my picture for educational and promotional purposes. If yes please initial_____

Health Information

Date of Last Dental Visit: _____ Reason for this visit:_____
Weight _____ Height _____ Blood Pressure_____/_____

Have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV
☐ Allergies _____
- ☐ Penicillin Allergy
- ☐ Sulfur
- ☐ Latex Allergy
- ☐ Pine Sap Allergy
- ☐ Tree Nut Allergy
- ☐ Codeine Allergy

_____

☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ **Pregnancy**
Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease

OTHER:
☐ _____

Tobacco Use:
Yes____ No_____

- Are you currently taking any medications? ☐ Yes ☐ No
  If yes, please list:_____
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____

To the best of my knowledge, all preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ _____
Signature of patient, parent or guardian **Date**

Race

☐ White ☐ Black/African American ☐ Hispanic ☐ Latino ☐ Arabic ☐ Asian ☐ Native American ☐ Hawaiian
☐ Other _____

Ethnicity

☐ Hispanic ☐ Non-Hispanic

Language

☐ English ☐ Hispanic ☐ Arabic ☐ Asian ☐ Other _____

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Responsible Party / Insurance Information

Primary

Name of Insured: _____ Is insured the patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____/____/_____ SSN: _____ID #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Financial Agreement and Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

There is no assurance of success that has been or can be given in dental treatment. There is always the possibility that further treatment may be necessary which may result in additional charges. In signing below you acknowledge full responsibility for the payment of all necessary services on the date treatment is started.

I understand that specific amount of time is allotted for my visit each time I schedule and the terms for cancellation have been explained to me. I understand if I need to cancel my appointment, I need to inform the office with 24-hour notice.

Smiles on Wheels preventative services include: Fluoride Treatments, Oral Health Education, Pit and Fissure Sealants, Prophylaxis, Assessments, Nutritional Counseling and Tobacco Cessation Counseling. These services may be obtained at the patient's dental home rather than by the PA 161 Program. Obtaining services from different offices may affect insurance benefits from private insurance companies, state and federal programs, or third-party provider benefits.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

SMILES ON WHEELS
122 Highland Drive
Jackson, MI 49201
517-740-7422
Website: www.smilesonwheels.org
Email: info@smilesonwheels.org

Access to Care Questionnaire

1. During the past 6 months, did (you/or your child) have a toothache?
1. No
2. Yes

2. When was you / or your child's last dental visit?
1. Within the last 6 months: Date_____
2. More than 6 months
3. More than 1 year ago
4. Over 5 years

3. What was the main reason that (you/or your child) last visited a dentist?
1. Exam / Assessment or Cleaning
2. Pain or Infection
3. Cavity or Broken Tooth

4.I am aware that (I/or my child) will still need a follow up appointment with a dentist.
1. Yes
2. No

5. During the past 12 months, was there a time when (you/or your child) needed dental care but could not get it at that time?
1. Yes
2. No

6. The last time (you/or your child) could not get the dental care (you/he/she) needed, what was the main reason (you/he/she) couldn't get care?
1. Could not afford it /No insurance
2. Dentist did not accept Medicaid/insurance
3. Difficulty in getting appointment
4. No dentist available
5. Didn't know where to go
6. Transportation issues
7. Speak a different language

HIPAA Acknowledgement

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements we have available on our website www.smilesonwheels.org and in our clinic our Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, contact an insurance carrier, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Please sign this form below to acknowledge that you have available or have received a copy of our notice of privacy practices by the above means.

_____ _____
Patient/Parent/Guardian Signature Patient Name (please print)

Signing for Dependent/Child(ren): _____
(Please print names)

Date: _____