

Access to Care Questionnaire

1. During the past 6 months, did you or your child have a toothache? **YES or NO**
2. During the past 12 months, was there a time when you or your child needed dental care but could not get it? **YES or NO**

IF YES, what was the main reason?

- | | |
|---|---|
| ☐ Could not afford it / No insurance | ☐ Dentist did not accept Medicaid / Insurance |
| ☐ No transportation | ☐ Difficulty getting an appointment / No dentist available |
| ☐ Language barrier | ☐ Did not know where to go |

3. What was the main reason you or your child last visited a dentist?
☐ Exam / Assessment or Cleaning ☐ Pain or Infection ☐ Cavity or Broken Tooth
4. I am aware that me, and or my child, will still need a follow up appointment with a dentist. **YES or NO**

HIPAA Acknowledgement

You and or your child's personal information is kept confidential and will not be shared with any person who is not directly involved in the care of you or your child as part of the Health Insurance Portability and Accountability Act (HIPAA). Our HIPAA privacy practice is available on our website www.smilesonwheels.org or in writing upon request.

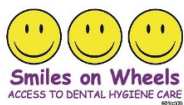
Financial Agreement and Consent for Services

We are committed to providing you with the best possible dental care! In order to achieve this, we need your assistance and your understanding of our payment policy. We will gladly answer any questions that we can about your insurance. As a courtesy to you, we will file claims with your dental insurance carrier on your behalf. Any portion not covered by insurance is your responsibility. *Co-payment is due on the date of service.*

I authorize my insurance company to pay Smiles on Wheels the insurance benefits on my behalf. I also authorize Smiles on Wheels to release any information they deem necessary in connection with my treatment and/or the treatment of my children to my insurance company and/or other health practitioners.

We expect that our patients honor the appointment times we reserve exclusively for them. We understand that your time is valuable and we appreciate the same respect in return. I understand if I need to cancel my appointment a 24-hour notice must be given to the office.

Signature: _____ Date: ____ / ____ / ____



122 Highland Dr., Jackson MI 49201 517-740-7422 Fax: 517-315-4918 Email: Info@smilesonwheels.org

Patient Name: _____ **Birth Date:** ____ / ____ / ____

Address: _____
Street Apt # City Zip Code

Cell Phone #: _____ **Other Phone #:** _____

Social Security #: _____ **Email Address:** _____

Gender: ____ Male ____ Female **Family Status:** ____ Married ____ Single ____ Child ____ Other

Race: ____ White ____ Black/African American ____ Hispanic ____ Arabic ____ Asian ____ Native American ____ Other

Ethnicity: ____ Hispanic ____ Non-Hispanic **Language:** ____ English ____ Hispanic ____ Arabic ____ Asian ____ Other

Dental Insurance Company Name: _____ **Insurance Phone #:** _____

Group #: _____ **Member ID # or SSN:** _____

Insured Name if other than patient: _____ **Insured Birth Date:** ____ / ____ / ____

Insured Employer: _____ **Employer Phone #:** _____

Health Information

Have you ever had any of the following? Please check all that apply: RDH Signature: _____ Date: ____ / ____ / ____

AIDS/HIV ____
Allergies _____
____ Penicillin
____ Sulfur
____ Latex
____ Pine Sap
____ Tree Nut
____ Codeine
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 Health Disorder ____
Nervous Disorder ____
Pacemaker ____
Pregnancy ____
Due Date _____
Radiation Treatment ____
Respiratory Problems ____
Rheumatic Fever ____
Rheumatism ____

Sinus Problems ____
Stomach Problems ____
Stroke ____
Tuberculosis ____
Tumors ____
Ulcers ____
Venereal Disease ____

OTHER: _____

Current Tobacco Use: YES or NO
Former Tobacco User: YES or NO

Are you currently taking any medications? YES or NO If yes, please list _____

Have you ever had any complications following dental treatment? YES or NO If yes, explain _____

Are you under the care of a doctor? YES or NO Name of Physician: _____

Have you ever been told you need to take antibiotics before dental treatment? YES or NO If yes, why? _____

Signature: _____ Date: _____