Smiles on Wheels
ACCESS TO DENTAL HYGIENE CARE
501(c)(3)

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: _____ / _____ / _____

Smiles on Wheels
ACCESS TO DENTAL HYGIENE CARE
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: _____

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