VINA Community Dental Center

"The Heart of Livingston County Dentistry"

We are pleased to provide the following information about the VINA Community Dental Center. Our mission is to provide quality, affordable dental care to eligible Livingston County residents with limited finances and no access to dental care while upholding the professional standards of dentistry in a concerned and compassionate way.

ELIGIBILITY: Patients must meet ALL 3 requirements:

1. **Individuals must live in Livingston County. 6 months legal residency is required.**
2. **Households must have NO dental insurance.**
3. **Households must have an income at or below 225% of federal poverty level. This also includes public assistance, social security, and unemployment.**

IMPORTANT INFORMATION:

Bring proof of family income and legal residence every 6 months to be re-qualified.

Your appointment will require a $25.00 fee to hold the appointment or be placed on the call list. We accept the following forms of payment: Cash
Money Order
Cashiers check
Credit Cards (VISA, MC, Discover)

WE DO NOT ACCEPT PERSONAL CHECKS

You will lose your appointment fee if you: **do not show up for your appointment**
cancel without a 48 hour notice
are late for your appointment

PLEASE SIGN BELOW:

I have provided the most up to date and true information. I authorize VINA Community Dental Center to verify all house hold income. I understand that this information will be kept confidential. I have read and understand all of the information about the care offered by VINA Community Dental Center. NOTICE: No patient is guaranteed services. Some services may be beyond VINA's ability to give basic care. VINA Community Dental Center is a non-profit organization that relies upon volunteer efforts. Patients must at all times follow ALL rules, requirements, and treatment plans. University of Michigan Dental Students or local Dental Hygiene Students under the supervision of one of our local volunteer dentists (adjunct faculty members) may provide care. VINA reserves the right to dismiss ANY patient if it determines, in its sole discretion that dismissal is in the best interest of the patient or the VINA Community Dental Center. Monies left in the account of any inactive patient for more than ninety days will be donated to VINA's Pay It Forward (PIF) fund.

Name of patient (please print): _____

Signature: _____ **Date:** _____

VINA COMMUNITY DENTAL CENTER

"THE HEART OF LIVINGSTON COUNTY DENTISTRY"

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION AND TREATMENT

TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By printing or signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations. An automated prescription record may be run at any time at the discretion of the treating dentist.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

I, _____ (Print name) have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices, I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

SIGNATURE

Signature: _____ **Date:** _____

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: _____ Relationship to Patient: _____

I consent the release of my protected information over the telephone to the following individuals:

Name of person: _____ Relationship: _____

Phone Number: _____ Alternate Phone: _____

Name of person: _____ Relationship: _____

Phone Number: _____ Alternate Phone: _____

I understand that the information used or disclosed pursuant to the consent may be subject to re-disclosure by the recipient and no longer protected by HIPAA. I also understand that this consent will remain in effect until revoked in writing.

Signature: _____ **Date:** _____

PATIENT INFORMATION:

Last Name: _____ First Name: _____ MI: _____Gender: M F Marital Status: S M

Date of birth: Month_____ Date: _____Year: _____ Age: _____ Insurance: ___Yes ___No

Home Address: _____City: _____State: _____ Zip: _____

Home Phone:_____Cell Phone:_____ Email:_____

Soc. Sec. #: _____ **Emergency Contact**: Name:_____ Phone: _____

Patient under guardianship/conservatorship: Person responsible: _____ Phone: _____

Do you have a "Durable Power of Attorney" for medical decisions? Yes No Name: _____Phone_____

Employed: _____ Address/city: _____

Work Phone: _____ Does your employer offer insurance?_____

No. of people in household: _____ Household Family Income: Wages: $_____ Unemployment: $_____Social Sec.: $_____

Public Assistance: $_____ other: $_____ Own a home? _____Total: $ _____

DENTAL HISTORY

Do your gums bleed when you brush? YES NO

Have you noticed any lumps or sores in your mouth? YES NO

Are your teeth sensitive to cold, hot, sweets or pressure? YES NO

Have you ever injured your face, jaws or teeth? YES NO

Are you happy with the appearance of you teeth? YES NO

Are you allergic to any metals or dental materials? YES NO

What types of dental treatment you have had? YES NO

Have you had problems with previous dental treatment? YES NO

If yes, please explain:

Do you have regular dental exams? YES NO

Orthodontics (braces) Dentures Root canal Implants

Oral Surgery Periodontal Treatment TMJ (Jaw) Treatment Fillings

Date Last Dental Exam: _____ Date Last X-rays: _____

Have you served in the military? YES

A detailed health history is invaluable for helping us treat you safely and effectively. Please be accurate, the confidentiality of this medical record is assured.

Are you in good general health? ☐ Yes ☐ No List any illness or disease that you have been treated for in the last two years: _____

List any prescription medications: _____

List any over-the-counter, natural or homeopathic medications: _____

List any known allergies: _____ List any recreational drugs used: _____

Doctor's name & phone_____

Are you allergic to latex? ..... ☐ Yes ☐ No
Have you ever had heart problems?..... ☐ Yes ☐ No
Have you ever had a heart attack? ..... ☐ Yes ☐ No
Have you ever been told that you have a heart murmur? ☐ Yes ☐ No
Do you have an artificial heart valve? ..... ☐ Yes ☐ No
Have you had a heart infection? ..... ☐ Yes ☐ No
Have you ever been told that you have a heart defect or congenital heart problems? ..... ☐ Yes ☐ No
Do you get chest pain or angina? ..... ☐ Yes ☐ No
Do you have jaw joint problems or a history of TMJ? ... ☐ Yes ☐ No
Do your ankles swell? ..... ☐ Yes ☐ No
Women: Are you pregnant or nursing? ..... ☐ Yes ☐ No
Do you have difficulty breathing or shortness of breath? ☐ Yes ☐ No
Have you ever had asthma attacks? ..... ☐ Yes ☐ No
Do you have a cough? ..... ☐ Yes ☐ No
Do you drink alcoholic beverages? ..... ☐ Yes ☐ No

Are you being seen by a psychologist or psychiatrist? If so what reason?
_____

How much do you smoke or vape? ☐ None ☐ pack/day ☐ packs/day ☐ More

Do you have active dental insurance?..... ☐ Yes ☐ No
Do you have a "Durable Power of Attorney" for medical decisions? ☐ Yes ☐ No
If yes: Name: _____ Phone: _____

Have you served in the military?..... ☐ Yes ☐ No
Have you ever had hepatitis? ..... ☐ Yes ☐ No
Do you have HIV/AIDS, or have you been exposed to AIDS? ☐ Yes ☐ No
Do you have problems with ulcers? ..... ☐ Yes ☐ No
Do you have digestive problems?..... ☐ Yes ☐ No
Do you have difficulty urinating? ..... ☐ Yes ☐ No
Do you urinate more than six times each day? ..... ☐ Yes ☐ No
Are you diabetic? ..... ☐ Yes ☐ No
Have you ever had seizures or convulsions? ..... ☐ Yes ☐ No
Have you ever had a stroke? ..... ☐ Yes ☐ No
Do you get cold sores?..... ☐ Yes ☐ No
Do you have any bleeding problems? ..... ☐ Yes ☐ No
Have you been anemic recently? ..... ☐ Yes ☐ No
Have you ever had cancer or radiation therapy? ..... ☐ Yes ☐ No
Do you have prosthetic or artificial joints? ..... ☐ Yes ☐ No

Have you in the past taken, or are you currently taking any medication for osteoporosis?..... ☐ Yes ☐ No

THIS INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE:

_____ _____

Signature of Patient or Representative **Date**

_____

Print Name