



## VINA Community Dental Center "The Heart of Livingston County Dentistry"

(810) 844-0240

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 of legal residency is required.
2. Households must have NO dental insurance.
3. Households must have an income at or below 250% 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

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**PLEASE SIGN BELOW:**

I have provided the most up-to-date and true information. I authorize VINA Community Dental Center to verify all household 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 always 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

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## CONSENT FOR THE 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 healthcare 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 had problems with previous dental treatment? YES NO

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

If yes, please explain:  
\_\_\_\_\_

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?

**Do you have regular dental exams? YES NO**

Orthodontics (braces) Denture Root Canal Implants

Date Last Dental Exam: \_\_\_\_\_ Date Last X-rays: \_\_\_\_\_

Oral Surgery Periodontal treatment TMJ (Jaw) Treatment Fillings

Have you served in the military? YES NO

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  1 pack/day  2 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