Family Health Care
Pediatric Dental

PATIENT REGISTRATION

Today's Date: _____

Patient Name: _____
Prefix (Mr., Mrs.) Last Maiden (if any) First Middle Initial Suffix (Jr., Sr.) Nickname

Social Security Number: _____ **Date of Birth:** _____ **Birth Sex:** ☐ M ☐ F

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Cell Phone #: _____ **Home Phone #:** _____ **Email Address:** _____

Patient's Employer: _____ **Phone #:** _____

Emergency Contact: _____ **Phone #:** _____

Appointment Reminder Contact Method: ☐ Phone ☐ Text ☐ Email

Preferred Language: ☐ English ☐ Spanish ☐ ASL ☐ Other: _____

How did you hear about FHC? (Please circle one)

Billboard	Facebook / Instagram / Social Media	Google / Yahoo / Search Engine	Phonebook	Other: _____
Brochure	Family / Friends	Insurance Carrier	Post Card	
Event	Flier / Poster	Newspaper / Magazine	Website	

If patient is a minor (under the age of 18) please complete the following:

Guarantor (Person financially responsible for minor patient)

Name: _____ Relationship to Patient: _____
Last First

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Parents of Minor Patient

Mother: _____ Date of Birth: _____

Father: _____ Date of Birth: _____

Insurance Information (*Please list all applicable coverage*)

Insurance #1: _____ **Contract #:** _____ **Group #:** _____

Subscriber's Name: _____ **Subscriber's Date of Birth:** _____

Employer's Name: _____

Billing Address - *Complete for Commercial Insurance only*: _____

_____

Effective Date of Coverage: _____

Please complete side 2

Insurance #2:_____ Contract #:_____ Group #: _____

Subscriber's Name:_____ Subscriber's Date of Birth: _____

Employer's Name:_____

Billing Address - *Complete for Commercial Insurance only*:_____

_____

Effective Date of Coverage: _____

By signing below, I authorize Baldwin Family Health Care (BFHC) and its affiliates to contact me by automated SMS text message for appointment reminders, marketing, and other information pertaining to my care. I understand that message / data rates may apply to messages sent by BFHC or its affiliates under my cell phone plan. I know that I am under no obligation to authorize BFHC or its affiliates to send me text messages. I may opt out of receiving these communications at any time by calling the office or by responding STOP to any message I receive from BFHC.

Please allow 2 - 3 business days for processing. I understand that text messaging is not a secure format of communication. There is some risk that individually identifiable health information or other sensitive or confidential information contained in such text may be misdirected, disclosed to or intercepted by unauthorized third parties. Information included in text messages may include your first name, date / time of appointments, name of physician, and physician phone number, or other pertinent information. By signing below, I indicate I am the primary user for the mobile phone number listed above, I accept the risk explained above and consent to receive text messages via automated technology from BFHC and its affiliates to the phone number that I have provided.

Signature required if requesting text message reminder

_____ _____

Signature of Patient (or Guardian) **Date of Signature**

Family Health Care Financial Policy Summary

We will file your claim to the Insurance(s) indicated. If we are unable to successfully collect reimbursement from your carrier, FHC will seek payment from the Guarantor indicated on the reverse side of this form.

FHC supports the policy of collecting deductibles, co-pays and any other related out of pocket expenses at time of service. Patients without insurance may be eligible for reduced fee services. If you are unable to pay at the time of service, you may meet with a Financial Counselor to establish payment arrangements.

This health center receives HHS funding and has Federal Public Health Service (PHS) deemed status with respect to certain health or health-related claims, including medical malpractice claims, for itself and its covered individuals.

All patients seeking an appointment for a work-related injury or illness must obtain written prior authorization from their employer before scheduling. If an appointment is scheduled without this authorization, the patient will be responsible for any expenses incurred during the visit, in accordance with BFHC payment policies.

I have reviewed the above statements and agree that I am responsible for any outstanding charges for all professional services provided.

_____ _____

Signature of Patient (or Guardian) **Date of Signature**

I authorize the release of any medical / dental / vision information necessary to process any claims.

_____ _____

Signature of Patient (or Guardian) **Date of Signature**

I authorize my Insurance Carrier to pay medical / dental / vision benefits directly to FHC on my behalf.

_____ _____

Signature of Patient (or Guardian) **Date of Signature**

Family Health Care
Pediatric Dental

Patient Name: _____ Date of Birth: _____

Definition of a failed or no-show appointment:

(1) An appointment that is cancelled with less than 24 hours advance notice.
(2) When a patient does not show up and does not call to cancel a scheduled appointment.
(Monday appointments should be cancelled the Friday before.)

OFFICE VISITS

- The **FIRST** time your child fails or no-shows for an appointment, our Family Health Care Dental Pediatric program will **NO longer schedule an appointment for you**. Your child will be offered same day or next day appointments, provided there are cancellations in the schedule.
- The **SECOND** time your child fails or no-shows an office visit, we will **only offer you same day emergency treatment for 30 days while you establish care at a different dental office**.

_____ _____
Parent/Guardian Initials Today's Date

SEDATION APPOINTMENTS

- The **FIRST** time your child fails or no-shows for a sedation appointment, we **will NOT immediately schedule another appointment** for your child. You will be offered a consultation with our pediatric dentist to discuss the care your child requires. Declining or cancelling (without proper notice) this consultation may result in the need to find a new dental home for your child.
- After the consultation, you may be offered an additional sedation appointment. If your child fails or no-shows a **SECOND** sedation appointment, **we will NOT schedule another sedation appointment and you will need to find your child a different dental home**.

_____ _____
Parent/Guardian Initials Today's Date

HOSPITAL APPOINTMENTS

- The **FIRST** time you fail or no-show for a hospital appointment we **will NOT schedule another appointment** for your child. You will be offered a consultation with our pediatric dentist to determine the appropriate course of treatment action for your child moving forward.
    - This may include but is not limited to:
        - No additional hospital appointments scheduled
        - Appointments offered in the office only
        - Finding a new dental home for your child.

  Declining or cancelling (without proper notice) this consultation may result in the need to find a new dental home for your child.

_____ _____
Parent/Guardian Initials Today's Date

Last minute cancellations and failed appointments occupy a valuable appointment time that could have been utilized to complete treatment on another child. Thank you in advance for your cooperation and understanding. We look forward to partnering in the oral health of your child.

_____ _____
Parent/Guardian Signature Today's Date

Family Health Care
Pediatric Dental

Child's Name: _____ DOB: _____ Nickname: _____ Sex: (M) (F)

Dental Concerns: _____

Name and age of brothers/sisters: _____ Is your child adopted? Y N

Child's Interests: _____ Name of Pet(s):_____

Does your child have any special needs? _____ Any phobias? _____

Child's learning: slow average accelerated Child's school: _____

HEALTH HISTORY

Child's Pediatrician: _____ Phone number: _____ Last Physical:_____

Is your child under a physician's care now? Y N If yes, reason: _____

Is your child taking any medications currently (including Bisphosphonates and over the counter)? Y N

If yes, please list: _____

Immunizations up to date? Y N Is your child allergic to any medication? Y N

If yes, please list: _____

Any history of hospitalization or surgery: (if yes, when) _____

Does your child have allergic reaction to: (please check all that apply)

__ Peanuts/Tree Nuts	__ Soy	__ Latex/Rubber	__ Pollen/Dust	__ Anesthetics
__ Eggs	__ Metals	__ Animals	__ Berries	__ Acrylic
__ Milk	__ Wheat/Gluten	__ Dyes/Coloring	__ Others: _____	

Has your child had a history or difficulty with any of the following?

ADHD/ADD	Y N	Cardiac Disease/Heart	Y N	Hearing Impaired	Y N
Anemia	Y N	Cerebral Palsy	Y N	Hepatitis	Y N
Arthritis/Joint Disorder	Y N	Chemo/Radiation	Y N	Immune Disorder	Y N
Asthma	Y N	Cystic Fibrosis	Y N	Kidney	Y N
Autism	Y N	Delayed Development	Y N	Liver	Y N
Bladder	Y N	Depression/Anxiety	Y N	Murmur	Y N
Bleeding Disorder	Y N	Diabetes	Y N	Muscular Disorder	Y N
Bone Disorder	Y N	Down's Syndrome	Y N	Premature Birth	Y N
Brain Injury	Y N	Earaches/Infections	Y N	Rheumatic Fever/Heart	Y N
Bruising	Y N	Eating Disorder	Y N	Speech Disorder	Y N
Cancer/Malignancy	Y N	Epilepsy/Seizure	Y N	Visual Impaired	Y N

Other: _____

DENTAL HISTORY

Is this your child's first dental visit? Y N If no, previous dentist: _____

Date of last visit: _____ How was the experience? _____

Were any x-rays taken? Y N

Child's attitude towards dentist or dental care: _____

Has your child had any injuries to teeth, mouth or head? Y N If yes, please describe: _____

_____

Has your child done any of the following (past or present)?

Please circle:

thumb/finger-sucking past present pacifier past present teeth grinding past present

nail biting past present lip sucking past present nursing past present

mouth-breathing past present snoring past present bottle feeding past present

Is your water fluoridated? Y N Does your child take fluoride supplements? Y N

How often does your child brush his/her teeth? _____ With adult supervision? Y N

How often does your child floss? _____

How may we help to make this visit as positive experience for your child?

_____

GENERAL INFORMATION

Who does child live with? _____

Parent(s) are: Married Divorced Single Widowed Partners

Mother's Name: _____ Father's Name: _____

What is the best way to reach parent(s)? _____

Email address for reminders: _____

Preferred Pharmacy: _____

Family Health Care

Dental Centers

1615 Michigan Avenue
Baldwin, MI 49304
Phone: 231-745-2736
Fax: 231-745-5050

730 Water Tower Rd
Big Rapids, MI 49307
Phone: 231-527-7264
Fax: 231-796-4109

520 Cobb Street
Cadillac, MI 49601
Phone: 231-876-6505
Fax: 231-876-6799

11 North Maple
Suite 200
P.O. Box 7
Grant, MI 49327
Phone:231-834-9750
Fax: 231-834-1459

1035 East Wilcox
P.O. Box 746
White Cloud, MI 49349
Phone: 231-689-1608
Fax: 231-689-3162

Permission Slip

Person with legal custody of patient ___ Mother ___ Father ___ Both ___ Other

(Legal custody gives a person the right to seek medical care on behalf of the patient. Most parents share joint legal custody).

Patient's Name: _____ DOB: _____

Please list any other person(s) who may bring the patient to Family Health Care Dental and consent to treatment:

Step Parent: _____ Step Parent: _____

Grand Parent: _____ Grand Parent: _____

Other: _____ Relationship to Patient: _____

Do you prefer to be here for a root canal or extraction of a tooth? Yes No

Does the patient have any allergies to any medications? Yes No

If you answered yes, please list: _____

_____ _____

Parent/Guardian Signature Date

Parent/Guardian Contact Numbers: Home: _____ Cell: _____

I understand that this consent is valid until I revoke this consent. I understand I may revoke this consent at any time by completing a new consent form.

Family Health Care

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT & SIGNATURE FORM

Patients Name (*Please Print*): _____ **Birthdate:**_____

The Notice of Privacy Practices describes how the Facility uses and discloses your health information and the circumstances under which we must seek your written permission to do so. The Notice of Privacy Practices also describes rights you have under federal regulations called the Health Insurance Portability and Accountability Act ("HIPAA"). HIPAA requires us to provide you with the Facility's Notice of Privacy Practices, and to obtain your written acknowledgment for receiving it.

By signing this form, you are acknowledging that the Facility provided you with its Notice of Privacy Practices; by signing, you are not agreeing or disagreeing with its content. If you do disagree, the Notice of Privacy Practices provides information about how you may address your concerns. By signing below, I acknowledge receiving the Facility's Notice of Privacy Practices.

(X)_____ _____
Signature of Patient or Representative Date

_____
Representative's Relationship to Patient (if applicable)

****

For Office Use Only

If an acknowledgment is not obtained, document below provider's good faith efforts to obtain the acknowledgment and the reason why the acknowledgment was not obtained:

Individual's name: _____
Date of attempt to obtain Acknowledgment: _____
Reason Acknowledgment was not obtained: _____

****

_____ I hereby acknowledge that I have received a copy of BFHC's Mission Statement and Patient Rights and
Initial Responsibilities.

I hereby authorize BFHC and the Provider assigned, as provided by law, to furnish medical/dental/optical, office surgery or diagnostic treatment and any local anesthetic as he/she considers necessary and proper in the treatment of the patient for the purpose of correcting his/her physical condition.

_____ This authorization shall be valid until rescinded in writing or replaced by one of a later date
Initial

I request that payment of authorized Medicare and/or insurance benefits be made on my behalf to Baldwin Family Health Care for any services rendered to me by them. I authorize any holder of medical/dental/optical information about me to release to the Centers for Medicaid and Medicare Services (CMS) and/or the Insurance Carrier and their Agents any information needed to determine these benefits of the benefits payable for related services. I acknowledge full responsibility for the payment of services and agree to pay for them at the time service is rendered, unless other arrangements are made.

_____ Note: Your blood may be tested for HIV or Hepatitis if an employee is exposed to your body fluids. This is in compliance
Initial with Public Act #448.

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BALDWIN FAMILY HEALTH CARE DISCLOSURE REQUEST

May we disclose health information about you to family members and friends who are involved in your care or the payment thereof?

- ☐ **Yes, you can discuss my care with any of my family members or friends that inquire about me.**
- ☐ **No, you can only disclose information to me.**
- ☐ **Yes, but only to the following individual(s):**

_____ _____
Name Relationship to patient Name Relationship to patient

****

(X)_____ _____
Signature Relationship, if not patient

_____ _____
Witness Date

This institution is an equal opportunity provider and employer
Baldwin Family Health Care is a Health Center Program grantee under 42 U.S.C. 254b, and a deemed Public Health Service Employee under 42 U.S.C. 233(g)-(n)

Family Health Care

Today's Date: _____

Dear Patient,

The information you provide helps us offer a wide range of services tailored to meet your needs. Your participation is greatly appreciated and ensures we can continue to improve our care and support for all our patients.

Patient Name: _____ **Date of Birth:** _____

Primary Medical Insurance: _____ **Medicare** _____ **Medicaid** _____ **Commercial** _____ **None**

Family Size: _____ **Family Size or Household Size is described as persons living under one roof in an interdependent relationship**

Family Gross Income: $_____ ☐ **Weekly** ☐ **Monthly** ☐ **Annually**

Race:

____More than one race
____American Indian/Alaskan Native
____Asian
____Asian Indian
____Black/African American
____Chinese
____Filipino
____Guamanian or Chamorro
____Japanese
____Korean
____Native Hawaiian
____Other Asian
____Other Pacific Islander (not Hawaiian)
____Samoan
____Unreported/Not Reported
____Vietnamese
____White

Ethnicity:

____Not Hispanic or Latino
____Arab/Chaldean
____Chicano
____Cuban
____Hispanic or Latino
____Mexican
____Mexican American
____Puerto Rican
____Spanish
____Unknown

Please check all that apply:

____ Military Veteran
____ Dependent of Seasonal/Migrant Worker
____ Require Translation Services_____ Native Language
____Seasonal/Migrant Worker
____Primary Language other than English
____Homeless

Gender Identity: (This is optional) _____

Sexual Orientation: (This is optional) _____

Family Health Care

PATIENT-CENTERED MEDICAL AND DENTAL HOME

PATIENT RIGHTS AND RESPONSIBILITIES

Our Mission: To provide quality, integrated and comprehensive health care services that are accessible to all.

Your Rights

1. You have a right to affordable health care and to apply to our sliding fee program.
2. You have a right to know our operating hours, services available and after hour coverage.
3. You are entitled to participate in treatment decisions and receive information concerning your diagnosis, treatment and prognosis. You may refuse care or treatment, but if you refuse treatment, you may be asked to sign a written release of responsibility.
4. You have the right to privacy per HIPAA guidelines.
5. You have the right to high quality and efficient health care from your Patient-Centered Home (PCH) team of support staff and providers who are trained to meet your Medical, Dental, Behavioral Health, Pharmacy and Optometry needs.
6. You may ask the names of your PCH team caring for you and their role in your treatment.
7. You have a right to choose your healthcare provider and the right to request a change of provider under extenuating circumstances.
8. You have the right to a response to your questions and obtain your test results.
9. You have the right to know the professional experience and certification of our medical, dental, behavioral health and optometry providers, the organization accreditation status and other measures of quality.
10. In most cases, you may look at or obtain copies of your medical, dental, behavioral health and/or optometry records. A fee may be charged for copies of your records.
11. Your guardian, next of kin, or legally authorized responsible person can exercise your rights for you and/or obtain your health information only per your prior written consent.
12. You will be notified in advance whenever practical if your provider cannot keep an appointment.
13. You have the right to voice a grievance with the Site Facility Manager if you are dissatisfied with your care or treatment.
14. You have the right to ask about End of Life Care options.
15. You have the right to be treated fairly and independently of your race, religion, ethnicity, color, national origin, gender, age, political beliefs, physical or mental impairments, marital status, sexual preference, sexual identity or source of payment.
16. You will not be deprived of any benefits, rights, or privileges guaranteed by federal or state law but subject to your responsibilities.
17. You have a right to influence the operation of Family Health Care through our Board of Directors, who represents the communities we serve.
18. You have the right to call your Family Health Care office after hours for urgent issues and will be helped by our on-call staff. (365 days/year).
19. You have the right to be informed and to consent in writing to minor surgical/dental procedures using local anesthesia performed at Family Health Care.
20. You have the right to request us not to bill your health plan if you pay upfront for services.
21. As a patient of Family Health Care, you have the right to have your prescriptions sent to the pharmacy of your choice.

Your Responsibilities

1. Be respectful of our health care providers, staff, other patients and facilities.
2. To schedule an appointment to see a provider except in unusual circumstances.
3. If, for any reason, you cannot keep your appointment, you should notify Family Health Care at least 24 hours before your appointment to reschedule so others may be seen.
4. You need to take an active role in your healthcare and inform your provider of all significant medical illnesses, surgeries, hospitalizations, Emergency Room visits, medications and allergies**.**
5. In order for the provider to arrive at a correct diagnosis and treatment plan, you must be open and honest about your symptoms, lifestyle, and concerns.
6. To respect others, you must avoid knowingly spreading infection and follow the recommended infection control practices of the clinic.
7. If your condition changes, or if you have a problem with your treatment, you should notify your PCH team immediately.
8. If you do not understand your diagnosis or treatment plan, you need to notify your PCH team.
9. Recognize the reality of risks and limits of the science of health care and human fallibility.
10. Inform your PCH team if you have a Living Will, Power of Attorney, or other Advanced Directives that could affect your end of life care.
11. If you do not actively participate in your health care, you may be asked to find another provider.
12. In most cases, we are able to bill your insurance for you; however you are responsible for payment of co-insurance deductibles and non-covered services at the time of your visit.
13. To address concerns that may arise, please utilize our internal grievance process by notifying the Site Facility Manager.
14. Be aware of a health care provider's obligation to be reasonably efficient and equitable in providing care to other patients and the community.

Family Health Care is a Health Center Program grantee under 42 U.S.C. 254b, and a deemed Public Health Service employee under 42 U.S.C. 233(g)-(n).

I have read and understand my responsibilities as a patient of this practice. I understand that it is imperative that I meet these responsibilities so that my Provider can provide the optimum care for me.

Patient's Name _____ Date of Birth _____

Patient/Parent/Legal Guardian Signature _____ Date _____

As your Provider, I understand my responsibilities to you as a patient of this practice. I will do my best to provide you with the highest quality of care possible.

Provider's Name _____