

## 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:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Home Phone #:** \_\_\_\_\_ **Work Phone #:** \_\_\_\_\_ **Cell Phone #:** \_\_\_\_\_

**Father:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Home Phone #:** \_\_\_\_\_ **Work Phone #:** \_\_\_\_\_ **Cell Phone #:** \_\_\_\_\_

**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.

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

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



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)

- |  |                                       |  |  |                                      |
|--|---------------------------------------|--|--|--------------------------------------|
| <input type="checkbox"/> Peanuts/Tree Nuts | <input type="checkbox"/> Soy          | <input type="checkbox"/> Latex/Rubber  | <input type="checkbox"/> Pollen/Dust   | <input type="checkbox"/> Anesthetics |
| <input type="checkbox"/> Eggs              | <input type="checkbox"/> Metals       | <input type="checkbox"/> Animals       | <input type="checkbox"/> Berries       | <input type="checkbox"/> Acrylic     |
| <input type="checkbox"/> Milk              | <input type="checkbox"/> Wheat/Gluten | <input type="checkbox"/> Dyes/Coloring | <input type="checkbox"/> 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?

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## 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: \_\_\_\_\_

## 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.



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.

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.

(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.

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

\*\*\*\*\*

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)

**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:**

<input type="checkbox"/> More than one race	<input type="checkbox"/> Chinese	<input type="checkbox"/> Other Asian
<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> Filipino	<input type="checkbox"/> Other Pacific Islander (not Hawaiian)
<input type="checkbox"/> Asian	<input type="checkbox"/> Guamanian or Chamorro	<input type="checkbox"/> Samoan
<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Japanese	<input type="checkbox"/> Unreported/Not Reported
<input type="checkbox"/> Black/African American	<input type="checkbox"/> Korean	<input type="checkbox"/> Vietnamese
	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> White

**Ethnicity:**

<input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> Cuban	<input type="checkbox"/> Mexican American
<input type="checkbox"/> Arab/Chaldean	<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Puerto Rican
<input type="checkbox"/> Chicano	<input type="checkbox"/> Mexican	<input type="checkbox"/> Spanish
		<input type="checkbox"/> Unknown

**Please check all that apply:**

<input type="checkbox"/> Military Veteran	<input type="checkbox"/> Seasonal/Migrant Worker
<input type="checkbox"/> Dependent of Seasonal/Migrant Worker	<input type="checkbox"/> Primary Language other than English
<input type="checkbox"/> Require Translation Services _____ Native Language	<input type="checkbox"/> Homeless

**Gender Identity: (This is optional)** \_\_\_\_\_

**Sexual Orientation: (This is optional)** \_\_\_\_\_

This institution is an equal opportunity employer and provider.



## 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