

Long Valley Health Center Intake Form

Patient Information Sheet and Consent Form

Chart/Account #: _____ Date: _____

Patient Name: _____ Date of Birth: ____/____/____
Last First Middle

Mailing Address: _____ HM Phone: _____ Cell Phone: _____
(Required) (PO Box/ Street #) City State Zip

Email: _____ Veteran: Yes _____ No: _____ (Current or completed service in Uniformed Services of U.S.)

Street Address: _____ Marital Status: M S D W Gender: M F
(Street #) City State Zip (Circle your selection)

Preferred Language: _____ SS#: _____ Drivers License: State: _____ Number: _____

Employer: _____ Address: _____ Wk Phone: _____

Race/Ethnicity (Circle one): Hispanic/Latino -- Asian -- Native Hawaiian -- Other Pacific Islander -- Black/African American (including Blacks or African Americans of Latino or Hispanic Descent) -- American Indian/Alaskan Native (including American Indians or Alaska Natives of Latino or Hispanic Descent) -- White (including Whites of Latino/Hispanic Descent) -- All Others -- More than one race -- Unreported/Refused to report

Emergency Contact: _____
(Name) (Phone)

How did you hear about us? (Circle one): Newspaper Phone Book Family/Friend School Healthy Start Other

Gross Family Income: Monthly/Yearly _____ Number in Family: _____

Insurance Information

Insurance Co. _____ Name of Insured: _____ Relation to Patient: _____

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

SS# / ID #: _____ Group #: _____ Medi-Cal #: _____

Responsible or Insured Party if Different from Above

Insured Party Name: _____ Date of Birth: ____/____/____
Last First Middle

HM Phone: _____ Cell Phone: _____

Mailing Address (if different): _____ City: _____ State: _____ Zip: _____

SS#: _____ Marital Status (circle one): M S D W Spouse Name, if applicable: _____

Employer: _____ Address: _____ WkPhone: _____

- Consent for Treatment:** I, the undersigned consent to the examination, immunizations, treatment and procedures for the care of the above named Patient. I understand that Physician' Assistants/Family Nurse Practitioner's (PA/NP) have been approved by the State of CA. to dispense drugs and medical supplies on the direct order of a physician or according to previously established written guidelines and that a physician is always available to the PA/NP for consultation during the assessment and treatment of patients.
- Release of Information:** To the extent necessary to determine the liability for payment and to obtain reimbursement, I authorize Long Valley Health Center to release portions of my medical records to any person, organization, or agency which is or maybe liable for all or any portion of the LVHC's charges. Including but not limited to insurance companies, health service plans, workman's compensation carriers and government agencies. The Dept. of Health Services may audit my medical records for the purpose of Center licensing or for statistical information. Such audits will not compromise the confidentiality of my medical record.
Exceptions:
- Financial Agreement:** I hereby agree that in consideration of services rendered by Long Valley Health Center to pay all bills as presented regardless of insurance coverage. I agree that if it becomes necessary the account will be referred to a collection agency and I shall pay the collection expenses in full.

Signature: _____ Date: _____ Relationship to Patient: _____
Office Use: _____ Date: _____ Title: _____

Patient Name _____
Patient Account No. _____

DENTAL HISTORY

Medical Alert _____

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today? _____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No

Do your gums bleed or hurt? Yes No

Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause _____

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

Are you satisfied with your teeth's appearance? Yes No

Would you like to keep all of your teeth all of your life? Yes No

Do you feel nervous about having dental treatment? Yes No

If so, what is your biggest concern? _____

Have you ever had an upsetting dental experience? Yes No

If yes, please describe _____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

Long Valley Health Center
Notice of Privacy Practices

Effective 4/15/03

**PATIENT ACKNOWLEDGMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES**

Medical Record Number: _____

Patient Name: _____

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for the above patient.

Signature

Relationship to patient

Date _____