Rite of Passage Patient Registration

Section 1. Instructions

Return completed forms[1] and supporting documentation to your local MACT Clinic or:

Mail: MACT Health Board, Inc.
Health Information Management
PO Box 939
Angels Camp, CA 95222

Fax: (209) 674-6200
Email: registration@macthealth.org[2]
Phone: (209) 754-6262

Registration forms and supporting documentation will be reviewed for completeness and processed in the order received. **Incomplete forms will not be processed and will delay your ability to establish care.** Once registration forms have been processed, you will be contacted to schedule your first appointment with each of the selected services in Section 2.

[1] For your convenience, this registration packet can be completed electronically by downloading the latest version of Adobe Acrobat Reader at https://get.adobe.com/reader/. Please note: MACT Health Board, Inc. does not endorse this product or Adobe Systems Incorporated.

[2] Information transmitted over the Internet may be at risk for loss of confidentiality. MACT Health Board, Inc. does not recommend sending confidential information, such as Social Security numbers over the Internet or via e-mail.

Section 2. Services

Services for all Rite of Passage "ROP" patients will be provided at our San Andreas facility. Please select the services that are of interest.

☐ Behavioral Health ☐ Dental ☐ Medical ☐ Optometry

Section 3. Standards of Behavior

MACT Health Board, Inc. "MACT" has a zero tolerance policy regarding the following:

- Public intoxication
- Drug or tobacco use on premises
- Violence
- Threats
- Weapons, of any kind
- Abusive language
- Inappropriate behavior
- Profanity
- Drug diversion
- Non-compliance with healthcare advice

I understand that any of the above mentioned actions and/or behaviors may result in my permanent dismissal from all MACT services and facilities. ____
Initial

Section 4. Care, Custody, Control, and Conduct

Do any of the following apply? (Check all that apply. Additional supporting documentation required.)

☐ Adoption
☐ Caregiver
☐ Court Ordered Parental Rights
☐ Emancipated Minor
☐ Foster Care
☐ Group Home
☐ Guardian ad Litem
☐ Kinship Care
☐ Legal Guardian
☐ Legal Name Change
☐ Self-sufficient Minor
☐ Tribal Customary Adoption

Section 5. Patient Information

Patient's Legal Name: ______________________ ________________ ________________________
First Middle Last

Gender Identity: ☐ Male ☐ Female ☐ Other: ________________ **Date of Birth**: ________________

Social Security Number[1]: ______________________ **Primary Language**: ________________________

[1] Failure to provide a social security number (SSN) or individual taxpayer identification number (ITIN) may prevent your ability to establish care and/or continue to receive services at MACT Health Board, Inc.

Physical Address: ____

City: __________________________________ **State**: _____________________ **Zip**: _____________

Mailing Address: ____

City: __________________________________ **State**: _____________________ **Zip**: _____________

Phone: ___________________________ __________________________ _______________________
Home Work Cell

Email Address: ____

Preferred Contact: ☐ Home ☐ Cell ☐ Work ☐ Text ☐ Email **Okay to leave a detailed message?** ☐ Yes ☐ No

American Indian or Alaskan Native Eligibility

_____________________________ _______________ ______________________ _______________
Tribe of Membership Roll Number Certificate of Indian Blood (CIB) State Where Enrolled

Race and Ethnicity

Please check one box that best describes your race or ethnicity.

☐ American Indian/Alaska Native
☐ Black or African American
☐ Hispanic or Latino[1]
☐ White
☐ Multiple Races[2]

Asian
☐ Multiple Asian[3]
☐ Cambodian
☐ Chinese
☐ Filipino
☐ Indian
☐ Japanese
☐ Korean
☐ Laotian
☐ Other Asian
☐ Vietnamese

Pacific Islander
☐ Multiple Pacific Islander[4]
☐ Guamanian
☐ Hawaiian
☐ Samoan
☐ Other Pacific Islander

[1] If you identify with Hispanic or Latino (alone or in combination with any other race)
[2] If you identify with more than one race that is not Hispanic or Latino, select Multiple Races.
[3] If you identify with more than one Asian ethnicity, select Multiple Asian.
[4] If you identify with more than one Pacific Islander ethnicity, select Multiple Pacific Islander.

Section 6. Parent or Legal Guardian Information

Primary Parent or Guardian Name: ______________________________

Gender Identity: ☐ Male ☐ Female ☐ Other: __________ **Date of Birth**: __________

Relationship to Patient:

☐ Parent ☐ County Case Worker ☐ Guardian ad Litem ☐ Other: __________
☐ Adoptive Parent ☐ Court-ordered Custodial Parent ☐ Legal Guardian
☐ Caregiver ☐ Foster Care Parent ☐ Social Worker

Social Security Number: __________ **Primary Language**: __________

Physical Address: ______________________________

City: __________ **State**: __________ **Zip**: __________

Mailing Address: ______________________________

City: __________ **State**: __________ **Zip**: __________

Phone: __________ Home __________ Work __________ Cell

Email Address: __________ **Employer**: __________

Preferred Contact: ☐ Home ☐ Cell ☐ Work ☐ Text ☐ Email **Okay to leave a detailed message?** ☐ Yes ☐ No

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Secondary Parent or Guardian Name: ______________________________

Gender Identity: ☐ Male ☐ Female ☐ Other: __________ **Date of Birth**: __________

Relationship to Patient:

☐ Parent ☐ County Case Worker ☐ Guardian ad Litem ☐ Other: __________
☐ Adoptive Parent ☐ Court-ordered Custodial Parent ☐ Legal Guardian
☐ Caregiver ☐ Foster Care Parent ☐ Social Worker

Social Security Number: __________ **Primary Language**: __________

Physical Address: ______________________________

City: __________ **State**: __________ **Zip**: __________

Mailing Address: ______________________________

City: __________ **State**: __________ **Zip**: __________

Phone: __________ Home __________ Work __________ Cell

Email Address: __________ **Employer**: __________

Preferred Contact: ☐ Home ☐ Cell ☐ Work ☐ Text ☐ Email **Okay to leave a detailed message?** ☐ Yes ☐ No

Section 7. Insurance Information

Do you have insurance? ☐ Yes ☐ No **Are you interested in our sliding fee scale?** ☐ Yes ☐ No

Medical Insurance

Primary Insurance Company: ____ ☐ N/A

Policy Number: ______________________ **Group Number**: ____________________

Guarantor Name: ________________________ **Date of Birth**: __________________

Secondary Insurance Company: ______________________________________ ☐ N/A

Policy Number: ______________________ **Group Number**: ____________________

Guarantor Name: ________________________ **Date of Birth**: __________________

Tertiary Insurance Company: ____ ☐ N/A

Policy Number: ______________________ **Group Number**: ____________________

Guarantor Name: ________________________ **Date of Birth**: __________________

Dental Insurance

Primary Insurance Company: ____ ☐ N/A

Policy Number: ______________________ **Group Number**: ____________________

Guarantor Name: ________________________ **Date of Birth**: __________________

Secondary Insurance Company: ______________________________________ ☐ N/A

Policy Number: ______________________ **Group Number**: ____________________

Guarantor Name: ________________________ **Date of Birth**: __________________

Vision Insurance

Insurance Company: ____ ☐ N/A

Policy Number: ______________________ **Group Number**: ____________________

Guarantor Name: ________________________ **Date of Birth**: __________________

Section 8. Financial Agreement

Financial Policy. MACT Health Board, Inc. "MACT" follows regulations and laws set by Indian Health Services and the State of California. Depending on your status, you will be financially responsible for all, part, or none of the services performed at any of our clinics, as well as any and all costs associated with the collection of services rendered. Proof of eligibility for Medicare, Medi-Cal, and contracted insurance companies is the responsibility of the patient. It is your responsibility to know your insurance plan, covered benefits, and co-pays and deductibles. MACT will submit insurance claims for patients whose insurance is provided by a health plan in which it contracts however; MACT expects same day payment for all co-payments, deductibles, and non-covered services. In cases where patients are required to pay cash for an appointment, a close approximation of the cost must be paid on the day services are rendered. If the actual cost of the treatment amount is different, the difference will be billed or refunded to the patient.

Authorization to Release Information and Assignment of Benefits. MACT has my permission to release information as needed for insurance processing and for my insurance to release payment to MACT Health Board, Inc.

Medicare Authorization: I agree that payment of authorized Medicare benefits be made on my behalf to MACT for any services provided. I authorize any holder of my medical information to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and I will be responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible amounts are based upon the charge determination of the Medicare carrier.

Section 9. Emergency Contact Information

Emergency Contact's Name: ______________________ __________________ ___________________________
First Middle Last

Relationship to Patient: _____________________________ **Phone Number**: ___________________________

☐ I decline to provide an emergency contact

Section 10. Pharmacy

MACT Health Board, Inc. "MACT" participates in the 340B Drug Pricing Program which may increase access and convenience to prescription drugs for our patients. Are you interested in changing your pharmacy to a pharmacy that has contracted with MACT for 340B pricing? ☐ Yes ☐ No

Preferred Pharmacy: ____

Phone: ____ **Fax**: ____

Address: ____

City: _______________________________________ **State**: ________________________ **Zip**: ______________

Section 11. Consent for Treatment

All non-emergency health care requires consent before treatment can be provided. When a patient is a minor, a parent or legal guardian usually must consent for that child's medical treatment. Placement into Rite of Passage does not automatically remove a parent or legal guardian's right to consent to health care.

Check all boxes that apply and provide supporting documentation, as necessary.

Court Order Is Required

☐ The patient has been declared a dependent child and the Juvenile Court has removed the parent or legal guardian's right to consent to medical treatment.

☐ The patient is in temporary custody. The county case worker may consent for necessary care and has notified the parent, guardian, or other person holding consent rights of her/his intent. The parent, guardian, or other person holding consent rights however; has objected and care cannot be provided without a court order authorizing treatment, unless it is an emergency.

- ☐ The court has granted the county case worker the right to consent to medical care on the patient's behalf.
- ☐ A separate court order which is different than a care, custody and control order, is required.
- ☐ The patient has been removed from her/his parents' custody and the child welfare agency has been given custody and control of the dependent child. A separate consent order is required and provided.

Court Order Is Not Required

☐ The patient is in temporary custody. The county case worker may consent for necessary care and has notified the parent, guardian, or other person holding consent rights of her/his intent. The parent, guardian, or other person holding consent rights has not objected and care can be provided without a court order authorizing treatment.

☐ Beyond ordinary care, the court has authorized a relative caregiver to provide the same legal consent for the minor's medical, surgical, and dental care as the custodial parent of a minor if, the child has been placed in a planned permanent living arrangement with that caregiver.

☐ The court has authorized treatment for the patient because a licensed physician has recommended treatment; notice has been provided to the patient's parent or guardian; and the juvenile court has found that no parent, guardian, or person standing in loco parentis is willing and able to provide consent. Certain special care requires a court order.

☐ The medical provider is unable to obtain consent in a timely manner and has decided to provide necessary emergency care without obtaining prior consent.

☐ This is an emergency situation that requires the patient to consent on her/his own behalf under federal or state law.

☐ This is an emergency situation. The county case worker may provide consent to necessary medical care and has made a reasonable attempt to notify the parent, guardian, or other person holding consent rights. No court order is required if this person objects.

Section 12. Special (Sensitive) Services

Certain sensitive services require the consent of the patient while others may require a court order or court authorization.

Check all boxes that apply and provide supporting documentation, as necessary.

☐ The patient is a minor and may consent to certain types of health care on her/his own accord.

☐ The patient is a minor less than 12 years of age. A court order is required for the following services:

1. HIV/AIDS: Testing and Treatment

☐ The patient is a dependent minor that needs psychotropic medication and has been removed from parental custody. Only the court has the authority to consent to the administration of psychotropic medication and may only do so upon a physician's request. However, the court may delegate this authority back to the parent(s) if it finds that the parent(s) pose no danger to the patient and has the requisite capacity. Court authorization is required.

☐ This is an emergency situation that requires the administration of psychotropic medication without court authorization. For this purpose, an emergency situation occurs when:

1. A physician finds that the child requires psychotropic medication to treat a psychiatric disorder or illness; and
2. The purpose of the medication is:
    a. To protect the life of the child or others, or
    b. To prevent serious harm to the child or others, or
    c. To treat current or imminent substantial suffering; and
3. It is impractical to obtain authorization from the court before administering the psychotropic medication to the child.

☐ If medication is administered in an emergency, court authorization still must be sought as soon as possible but no later than two (2) court days after the emergency administration of the psychotropic medication.

Section 13. Additional Required Documentation

In addition to the completion of this form, provide any of the following pertinent court documentation to MACT Health Board, Inc.

Check all boxes that apply and provide supporting documentation, as necessary.

If there is a court order related to California Welfare and Institutions Code Sections 366.24, 366.26, 727.3, and/or 727.31, provide:

☐ **Orders Under Welfare and Institutions Code Sections 366.24, 366.26, 727.3, 727.31 (Form JV-320)**

If there is a court order related to California Welfare and Institutions Code Sections 361 et seq., provide:

☐ **Findings and Orders After Dispositional Hearing (Form JV-415)**

If there is a court order with an additional dispositional attachment related to California Welfare and Institutions Code Sections 361 and/or 361.2, provide:

☐ **Dispositional Attachment: Removal from Custodial Parent – Placement with Previously Noncustodial Parent (Form JV-420)**

☐ **Dispositional Attachment: Removal from Custodial Parent – Placement with Nonparent (Form JV-421)**

If the court has authorized psychotropic medication for a dependent, provide:

☐ **Order on Application for Psychotropic Medication (Form JV-223)**

The following forms which support Form JV-223 may also be provided but are not required:

☐ **Application for Psychotropic Medication (Form JV-220)**

☐ **Physician's Statement – Attachment (Form JV-220A) or**

☐ **Physician's Request to Continue Medication – Attachment (Form JV-220B)**

If the patient has been provided any of the following forms and any of these forms pertain to the care, custody, control, and/or conduct over the patient, provide all that apply:

☐ **Termination of Dependency (Juvenile) (Form JV-364)**

☐ **Termination of Juvenile Court Jurisdiction Nonminor (Form JV-365)**

☐ **Findings and Orders After Hearing to Consider Termination of Juvenile Court Jurisdiction Over a Nonminor (Form JV-367)**

☐ **Disposition – Juvenile Delinquency (Form JV-665)**

☐ **Custodial and Out-of-Home Placement Disposition Attachment (Form JV-667)**

If the parent is providing health insurance or has been court ordered to provide health insurance coverage for the patient, provide:

☐ **Application and Order for Health Insurance Coverage (Form FL-470)**

☐ **A copy of the patient's health insurance card**

If the parent has terminated her/his employment and/or benefits and is required to provide health insurance coverage for the patient, provide:

☐ **Termination of Benefits/Employment Notice (Form DCSS-0114)**

If the patient has received a Medi-Cal Benefits Identification Card (BIC), provide:

☐ **Medi-Cal Benefits Identification Card (BIC)**

Section 14. Acknowledgements and Authorization

By signing this document, you certify that the information provided throughout this form is true and accurate. Additionally, you indicate receipt, understanding, and acceptance of the following MACT Health Board, Inc. forms and policies:

1. Appointment Cancellations and No-Shows
2. Financial Agreement
3. Notice of Privacy Practices
4. Standards of Behavior
5. **For Dental Patients**: Dental Board of California's Dental Materials Fact Sheet

Furthermore, you acknowledge and accept that MACT Health Board, Inc. employs and uses the services of **Non-Physician Medical Practitioners (NMPs)** such as Physicians Assistants and Nurse Practitioners. You may be treated by an NMP.

I/we certify that I/we have read and understand the above information to the best of my/our knowledge. The undersigned patient, and/or responsible party gives permission for MACT Health Board, Inc. to administer healthcare treatment and advice as necessary.

______________________	______________________	___/___/_____	______________________
Print Name of Patient	Signature of Patient[1]	MM DD YYYY	Relationship to Patient
______________________	______________________	___/___/_____	______________________
Print Name of Parent/Authorized Representative	Signature of Parent/Authorized Representative[2]	MM DD YYYY	Relationship to Patient

[1] The signature of the patient is only required if s/he is legally capable of consenting to her/his own care and/or treatment.

[2] If this form is completed and signed by a non-custodial parent, including but not limited to a legal guardian, person(s) having legal custody of the minor, or a caregiver of the child who is a relative of the child and who may authorize medical care and dental care under Section 6550 of the California Family Code, supporting legal documentation is required.

Section 15. Further Instructions

Please return the following forms to MACT Health Board, Inc. as instructed in Section 1:

☐ Pages 1-9 of the Rite of Passage Patient Registration Packet and supporting documentation

☐ Health History Questionnaire

☐ **For Medicare Patients**: Medicare Secondary Payer Questionnaire

☐ Authorization for Use or Disclosure of Protected Health Information, optional

☐ Authorization for Third-Party Consent to Treatment of Minor Lacking Capacity to Consent, optional

☐ Permission to Verbally Discuss Protected Health Information, optional

Behavioral Health-Related Documentation

☐ Treatment summary letter with diagnosis, if possible/applicable

☐ Treatment plan, if possible/applicable

☐ Current or past medication contraindications, if possible/applicable

☐ Therapy summary, if possible/applicable

Health History Questionnaire (Child)

Patient Name: ______________________________ **Date**: ____________________

Date of Birth: ______________________________ **MRN**: ____________________
Internal Use Only

1. Most Recent **Physician's** Name: ______________________________ ☐ None

   Phone: ____________________ Fax: ____________________

   Address: ______________________________

   City: ____________________ State: ____________ Zip: ____________

2. Most Recent **Dentist's** Name: ______________________________ ☐ None

   Phone: ____________________ Fax: ____________________

   Address: ______________________________

   City: ____________________ State: ____________ Zip: ____________

3. Most Recent **Optometrist's** Name: ______________________________ ☐ None

   Phone: ____________________ Fax: ____________________

   Address: ______________________________

   City: ____________________ State: ____________ Zip: ____________

4. Have you been under the care of a medical doctor during the past two years? ☐ Yes ☐ No

   If Yes, for what? ______________________________

Medications

5. Are you taking any medication including non-prescription drugs? ☐ Yes ☐ No
   If yes, please list name(s) and dosage:

   Medication: ______________________________ Dosage: ____________________

Medication: ______________________________ Dosage: ____________________

Medication: ______________________________ Dosage: ____________________

Medication: ______________________________ Dosage: ____________________

Medication: ______________________________ Dosage: ____________________

Medication: ______________________________ Dosage: ____________________

Medication: ______________________________ Dosage: ____________________

Medication: ______________________________ Dosage: ____________________

6. Do you take **BISPHOSPHONATE** medications? ☐ Yes ☐ No ☐ Unsure

Household

7. Please list all those living in your/child's home.

Name	Relationship to You/Your Child	Date of Birth	Health Problems

8. Are there siblings not listed? If so, please list their names, ages, and where they live.

9. What is your/child's living situation if not with both biological parents?
   ☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody ☐ Lives with foster family

10. If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

Birth History

☐ Don't know birth history

11. Birth weight: ______________________________ ☐ Unsure
12. Was the baby born at term? ☐ Yes ☐ No ☐ Unsure
    a. If no, how many weeks along? ______________________________
13. Was the delivery ☐ vaginal ☐ cesarean? ☐ Unsure
    a. If cesarean, why? ______________________________
14. Were there any prenatal or neonatal complications? ☐ Yes ☐ No ☐ Unsure
    a. If yes, explain: ______________________________
15. Was a NICU stay required? ☐ Yes ☐ No ☐ Unsure
    a. If yes, explain: ______________________________
16. During pregnancy, did mother: ☐ Use tobacco ☐ Drink alcohol ☐ Use drugs or medications ☐ Use prenatal vitamins
17. Was initial feeding: ☐ formula ☐ breast milk?
18. How long were you/your child breastfed? ______________________________
19. Did you/your baby go home with mother from the hospital? ☐ Yes ☐ No ☐ Unsure

General

20. Do you consider yourself/your child to be in good health? ☐ Yes ☐ No ☐ Unsure
21. Do you/your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ Unsure
22. Have you/your child had any surgery? ☐ Yes ☐ No ☐ Unsure
23. Have you/your child ever been hospitalized? ☐ Yes ☐ No ☐ Unsure
24. Are you/your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ Unsure
25. Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ Unsure

Allergies

26. Are you aware of having an allergic or adverse reaction to any medication, food or substance? ☐ Yes ☐ No

☐ Sulfa drugs	☐ Metals (nickel, mercury, etc.)	☐ Sedatives
☐ Barbiturates	☐ Penicillin or other antibiotics	☐ Aspirin
☐ Iodine	☐ Local anesthetics (e.g. Novocain)	☐ Latex

Medication/Food/Substance: ______________________________ ☐ Allergic ☐ Adverse

Medication/Food/Substance: ______________________________ ☐ Allergic ☐ Adverse

Medication/Food/Substance: ______________________________ ☐ Allergic ☐ Adverse

Past History and Current Conditions

27. Indicate which of the following you/your child have had, or have at present (**check all that apply**):

☐ Heart (surgery, disease, attack)
☐ Chest pain
☐ Congenital heart disease
☐ Heart murmur
☐ High blood pressure
☐ Mitral valve prolapse
☐ Artificial heart valve
☐ Heart pacemaker
☐ Arthritis/rheumatism
☐ Swollen ankles
☐ Stroke
☐ Diet (special/restricted)
☐ Obesity
☐ Artificial joints (hip, knee, etc.)
☐ Kidney disease or urologic malformations
☐ Drug or alcohol use/abuse
☐ Tobacco use
☐ Thyroid or other endocrine problems
☐ Ulcers
☐ Diabetes
☐ Glaucoma
☐ Emphysema
☐ Chronic cough
☐ Tuberculosis
☐ Asthma, bronchitis, or pneumonia
☐ Latex sensitivity
☐ Allergies or hives
☐ Nasal allergies
☐ Sinus trouble
☐ Radiation therapy
☐ Chemotherapy
☐ Tumors/cancer
☐ Anemia or bleeding problem
☐ Malignancy/bone marrow transplant
☐ Hepatitis A, B, C
☐ Sexually transmitted infection
☐ AIDS
☐ HIV
☐ Cold sores/fever blisters
☐ Blood transfusion
☐ Hemophilia
☐ Sickle cell disease
☐ Bruise easily
☐ Liver disease
☐ Neurological disorders and/or convulsions
☐ Epilepsy or seizures
☐ Fainting or dizzy spells
☐ Frequent headaches
☐ Nervousness/anxiousness
☐ Psychiatric/psychological care
☐ ADHD/anxiety/mood problems/depression
☐ Chickenpox
☐ Frequent ear infections
☐ Problems with ears of hearing
☐ Problems with eyes or vision
☐ Organ transplant
☐ Frequent abdominal pain
☐ Constipation requiring doctor visits
☐ Recurrent urinary tract infections and problems
☐ Congenital cataracts/retinoblastoma
☐ Metabolic/genetic disorders
☐ Bed-wetting (after 5 years old)
☐ Sleep problems; snoring
☐ Chronic or recurrent skin problems (acne, eczema)
☐ History of serious injuries/fractures/concussions
☐ Developmental delay
☐ Dental decay
☐ History of family violence
☐ Other: ______________________________

For Females

☐ Problems with your/her periods
☐ Has had first period
☐ Age of first period: _________
☐ Pregnancy
☐ Nursing
☐ Taking birth control pills

Biological Family Medical History

28. Do any of the following conditions run in your family? (**check all that apply**)

☐ None
☐ Childhood hearing loss
☐ Nasal allergies
☐ Asthma
☐ Tuberculosis
☐ Heart disease (before age 55)
☐ High cholesterol/takes cholesterol medication
☐ Anemia
☐ Bleeding disorder
☐ Dental decay
☐ Cancer
☐ Liver disease
☐ Kidney disease
☐ Diabetes (before age 55)
☐ Bed-wetting (after age 10)
☐ Obesity
☐ Epilepsy or convulsions
☐ Alcohol abuse
☐ Drug abuse
☐ Mental illness/depression
☐ Developmental disability
☐ Immune problems, HIV, or AIDS
☐ Tobacco Use
☐ Other: ________________________________

Immunizations

29. Please provide the approximate dates of the following immunizations or select ☐ Unknown

Tetanus: _________ __________ Influenza: _________ __________ Pneumonia: _________ __________
Month Year Month Year Month Year

Present Dental Conditions, Treatments, and Appliances

30. Do your gums bleed while flossing or brushing? ☐ Yes ☐ No
31. Do you experience tooth sensitivity to hot/cold foods/liquids? ☐ Yes ☐ No
32. Do you experience tooth sensitivity to sweet/sour foods/liquids? ☐ Yes ☐ No
33. Are you experiencing the presence of sores or lumps in or near your mouth? ☐ Yes ☐ No
34. Are you experiencing pain in a specific location? ☐ Yes ☐ No
35. Do you have a history of head, neck or jaw injuries? ☐ Yes ☐ No
36. Are you experiencing jaw pain (joint, ear, side of face)? ☐ Yes ☐ No
37. Are you having difficulty opening or closing? ☐ Yes ☐ No
38. Do you bite your lips and/or cheeks frequently? ☐ Yes ☐ No
39. Do you experience jaw clicking? ☐ Yes ☐ No
40. Do you have difficulty chewing? ☐ Yes ☐ No
41. Do you experience frequent headaches? ☐ Yes ☐ No
42. Do you clench your teeth? ☐ Yes ☐ No
43. Do you grind your teeth? ☐ Yes ☐ No
44. Have you experienced prolonged bleeding? ☐ Yes ☐ No
45. Have you undergone orthodontic treatment? ☐ Yes ☐ No
46. Do you have full or partial dentures? ☐ Yes ☐ No
47. Do you snore while sleeping? ☐ Yes ☐ No
48. In the past, have you had to take an antibiotic before dental treatment? ☐ Yes ☐ No

Vision History

49. When was your last eye exam? ____ ☐ N/A
50. Do you wear glasses? ☐ Yes ☐ No
51. Do you have blurry vision? ☐ Yes ☐ No
52. Have you ever had any eye surgery in the past? ☐ Yes ☐ No
53. Have you ever had any of the following symptoms? ☐itching ☐burning ☐tearing ☐pain ☐flashes ☐floaters
54. Do you have any disease, condition, or problem not listed above? ☐ Yes ☐ No

If Yes, please explain: ____

Acknowledgement

I understand the above information is necessary to provide me with medical, dental, behavioral health, and/or vision care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you.

Additionally, if I ever have any changes in my personal information, health status, or my medication, I will inform my provider(s) at my next appointment, at the latest.

______________________	______________________	____/____/_____	______________________
Print Name of Patient	Signature of Patient[1]	MM DD YYYY	Relationship to Patient
______________________	______________________	____/____/_____	______________________
Print Name of Parent/Legal Guardian	Signature of Parent/Legal Guardian[2]	MM DD YYYY	Relationship to Patient

[1] The signature of the patient is only required if s/he is legally capable of consenting to her/his own care and/or treatment.

[2] If this form is completed and signed by anyone other than a custodial parent(s) of a minor, including but not limited to a legal guardian(s), person(s) having legal custody of the minor, or a caregiver of the child who is a relative of the child and who may authorize medical care and dental care under Section 6550 of the California Family Code, supporting legal documentation is required.

For Internal Use Only

HT: **WT:** **BP:** **/** **P:** **TEMP:** **BG:** **AGE:**

Reviewed By: ____ Date: ____________________