CARING HANDS
HEALTHCARE CENTERS
QUALITY AFFORDABLE CARE

How did you hear about Caring Hands?

_____

PAYMENT IS EXPECTED AS SERVICES ARE RENDERED

Thank you for choosing our office.
In order to serve you properly we will need the following information. All information will be strictly confidential.
PLEASE PRINT

PATIENT INFORMATION

Patient's Last name, First M.I.	Preferred Name/Nickname:	Social Security Number:	Birth Date:
Birth Sex: ☐Male ☐Female	Gender Identity (18+) ☐Male ☐Female ☐Declined ☐Other ☐Transgender Male (FtoM) ☐Transgender Female (MtoF)	Sexual Orientation (18+) ☐Straight ☐Gay ☐Lesbian ☐Bisexual ☐Other ☐Declined	
Street Address	City:	State:	Zip Code:
Billing Address	City:	State:	Zip Code:
Home Phone	Day Phone	Cell Phone	Work Phone
Email:	Driver's License Number	Occupation	Employers Name
Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widow/Widower		Student: ☐Full-Time ☐Part-Time ☐Not a current student	
Homeless: ☐Yes ☐No	Migrant Worker: ☐Yes ☐No	Primary language	Public Housing
Race:	Hispanic: ☐Yes ☐No	Veteran: ☐Yes ☐No	Smoker: ☐Yes ☐No
# of people in household:	Please indicate primary insurance: ☐Medicaid ☐Medicare ☐Self-Pay ☐Commercial Insurance		

If you have Medicaid/Medicare or Commercial Insurance, what is your annual household income? $_____
☐Refuse to Report

IN CASE OF EMERGENCY

Name of local friend or relative	Relationship to patient	Home Phone #

I, the undersigned, certify that I (or my dependent) have insurance with _____ and assign directly to Caring Hands Healthcare Centers, Inc. all insurance benefits, if any, otherwise payable to me. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Caring Hands Healthcare Centers, Inc. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I agree to be responsible for payment of all services rendered on my behalf (or my dependent). I understand that payment is due at the time of service, unless other arrangements have been made. In the event that payments are not received by agreed upon dates, I understand that refusal to be seen can and will be enforced until payment is rendered.

Patient/Guardian Signature _____Date _____

MEDICAL AND DENTAL HISTORY

CARING HANDS HEALTHCARE CENTERS

Patient Name: _____ DOB: _____

MEDICAL HISTORY

Name of Physician: _____ Phone: _____

Physician's Address: _____

When was your last physical? _____

Are you now under the care of a physician? YES / NO

If Yes, for what reason? _____

Are you presently taking any medications/drugs/pills? YES / NO

If yes, please list: _____

Are you allergic (or have an adverse reaction) to?

◯ Penicillin ◯ Codeine ◯ Local Anesthetic ◯ Aspirin ◯ None

◯ Other ◯ Other Antibiotic Please describe: _____

Are you sensitive or allergic to latex? (i.e. Experienced itching, rash or wheezing after using latex gloves or handling a balloon)
YES / NO If yes, please explain: _____

Have you had any unusual or unexplained reactions during a surgical procedure? YES / NO
If yes, please explain: _____

Do you have, or have you had any of the following: (Check all that apply)

◯ Heart Disease/Surgery
◯ Heart Murmur
◯ Heart Pace Maker
◯ Rheumatic Fever
◯ Rheumatic Heart Disease
◯ Congenital Heart Disease
◯ Artificial Heart Valve
◯ Mitral Valve Prolapse
◯ Abnormal Blood Pressure
◯ Ulcers
◯ Sinus Trouble
◯ Cancer
◯ Tumors
◯ Chemotherapy
◯ Radiation Therapy
◯ Stroke
◯ Hearing Impaired
◯ Tuberculosis
◯ Lung Disease
◯ Diabetes
◯ Epilepsy
◯ Anemia
◯ Thyroid Problems
◯ Chemical Dependency
◯ Kidney Problems
◯ Hepatitis □A □B □C
◯ Emphysema
◯ Anorexia
◯ Bulimia
◯ Neurological Disorders
◯ Prosthetic Implants
◯ Artificial Joint
◯ Glaucoma
◯ Liver Disease
◯ Learning Disability
◯ Arthritis/Rheumatism
◯ Cortisone Medicine
◯ Prolonged Bleeding
◯ Hemophilia
◯ Sickle Cell Disease
◯ Fainting Spells
◯ Asthma
◯ Psychiatric Care
◯ Organ Transplant
◯ Removal of Spleen
◯ Alcohol Addiction
◯ Drug Dependency
◯ HIV Positive/AIDS
◯ Venereal Disease

Have you had any other serious illness, hospitalization or accident? YES / NO
If yes, please explain: _____
Do you currently smoke or use the following tobacco products? ◯ Cigarettes ◯ Cigars ◯ Pipe ◯ Chew ◯ None
Have you used tobacco products in the past? YES / NO If yes, how long ago? _____
Do you drink alcoholic beverages? YES / NO If yes, how much? _____
WOMEN: Are you pregnant? YES / NO Are you nursing? YES / NO Do you take birth control medications? YES / NO

DENTAL HISTORY

Previous Dentist's Name: _____ Phone: _____

Previous Dentist's Address: _____

Date of Last Visit: _____ Last Hygiene Visit: _____ Last x-rays: _____

How often do you have dental examinations? _____

What is the nature of today's visit? ◯ Regular Exam ◯ Emergency: _____
◯ Other: _____

Do you have any dental problems now? YES / NO If yes, please describe: _____

Does dental treatment make you nervous? YES / NO

Is there anything about receiving dental care that concerns you? YES / NO
If yes, explain: _____

Any sensitivity to: ◯ Cold ◯ Hot ◯ Sweets ◯ Chewing

Do you have any of the following? ◯ Bleeding gums ◯ Bad Breath ◯ Grind teeth at night ◯ Clicking jaw

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

What other aids do you use? (Electric toothbrush, toothpick, etc.): _____

Comments:

Patient/Guardian Signature: _____ Date: _____

Informed Consent

Patient Name:_____ DOB:_____ Gender:_____

I hereby authorize my dentist and whomever they designate as their assistants or hygienists, to perform the dental procedures which we discussed and I accept the treatment plan. If any unforeseen condition arises in the course of treatment I request and authorize whatever they deem advisable. I consent to the treatment plan I have accepted after having been advised of alternate plans of treatment available.

I am informed and fully understand that there are certain risks in any dental treatment. These risks include but are not limited to: post-treatment pressure and temperature sensitivity, pain or throbbing, pulpal inflammation, fracturing of new restorations due to early biting pressures, tenderness of adjoining teeth, tenderness of tissues under removable dentures, swelling and re-infection or sensitivity of the teeth and gums during and following dental cleanings.

I further consent to the administration of any drugs that may be deemed necessary in my case, including, but not limited to: local anesthetics, antibiotics and analgesics. I understand that there is a slight element of risk in the administration of any drugs or anesthesia. Risks include, but are not limited to: adverse drug response, aspiration, pain, discoloration or injury to blood vessels or nerves which may be caused by injections of any medications or drugs.

ENDODONTICS

I understand that Endodontic Therapy is an attempt to save a tooth that may otherwise by extracted. The indications for Endodontic Therapy may include: loss of vitality, infection or in certain restorative procedures to obtain sufficient retention or a restoration. The tooth may eventually darken due to endodontic treatment.

Other factors may influence successful treatment including: calcified, inaccessible or curves canals, internal and/or external resorption of the canal(s), accidental broken instruments within the canal(s) or fracture of the crown or root. An apicoectomy may be indicated to remove the apical portion of the tooth to resolve or clear an infection. In some cases a crown and possibly a post may be recommended. Either or both of these procedures are to be considered integral to the successful treatment of the tooth.

ORAL SURGERY

In oral surgery the most common complications include post-operative bleeding, swelling, bruising, stiff jaw, loss or loosening restorations, pain, infection, temporary or permanent numbness, tingling of the lip, tongue, chin, injury to or stiffness of the neck and facial muscles and change in bite or temporo-mandibular joint, nausea or vomiting, allergic reactions, bone fracture, delayed healing, sinus exposure and swelling or aspiration of teeth and restorations. A full explanation of all complications of surgery and anesthesia is available to me upon request from the doctor.

I realize that it is mandatory that I give an accurate and complete medical and personal history and follow all instructions as directed.

I am aware that in spite of the possible complications and risks, my treatment is necessary and desired by me. I realize that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the procedures.

Procedures:

Patient/Guardian Signature: _____ Date: _____

Dental Clinic

CARING HANDS
HEALTHCARE CENTERS

We use fluoride in our office that may contain artificial sweeteners, such as strawberry and banana. Please let us know if you have had any type of allergic reaction to these particular products. Circle Yes or No

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.
I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Patient Signature: _____

Date: _____

Reviewed by: _____

_____

_____

Consent for Treatment and for Use of Health Information

1. I _____ (patient name) give permission for **Caring Hands Healthcare Center** to provide me diagnostic and therapeutic treatment utilizing any of the services the center may provide as deemed necessary or advisable during my care.

2. I allow **Caring Hands Healthcare Center** to file for insurance benefits to pay for the care I receive. I also allow Caring Hands Healthcare Center to use my health information for its operational needs, such as peer review and quality assurance.

   I understand that:
   - **Caring Hands Healthcare Center** will have to send my medical record information to my insurance company.
   - I must pay my share of the costs.
   - I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

3. I understand that:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my clinician.
   - That my health information may be shared according to the Notice of Privacy Practices as provided to me and acknowledged in writing by me

_____ _____

Patient's Signature Date

_____ _____

Parent or Guardian Signature Date
(for children under 18)

December 2019

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

Notice to Patient or Patient's Legally Appointed Representative:

We are required to provide you with a copy of our Notice of Privacy Practices which describes how Caring Hands Healthcare Centers, Inc may use or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may decline to sign this acknowledgement if you wish.

I acknowledge that I have received a copy of the Notice of Privacy Practice for Caring Hands HealthCare Centers.

_____ _____
Signature **Date**

_____
Printed Name

Relationship to the Patient if not signed by the Patient personally (*i.e.*, legal guardian, holder of durable power of attorney for health care, health care proxy, parent of a minor patient)___

_____

FOR OFFICE USE ONLY

Caring Hands Healthcare Centers, made every effort to obtain the written acknowledgement of receipt of this practice's Notice of Privacy Practices from this patient but was unable to do so because:

☐ **The patient or legally appointed representative of the patient refused to sign**

☐ **It was impossible to obtain a signature because of an emergency situation**

☐ **Other (provide specific details):**_____

_____

_____

_____ _____
Employee Signature **Date**

_____
Employee Printed Name

Designation of Individuals Whom My Providers Can Discuss My Healthcare

Federal rules that our practice must follow protect the privacy and security of your health information. All the ways we use your health information and your rights under the Health Insurance Portability and Accountability Act, or HIPAA, are described in our Notice of Privacy Practices that you were offered when you first received care from us.

In the course of our providing care to you, you may wish to make it easier for us to speak with your family members and others who may assist in my care. If you bring someone with you to your appointment and you bring them into the examination room with you, we consider that to be your consent to allow us to discuss your care in front of them. If you do not want them to be included in our discussion, please ask them not to come with you into the exam room. Sometimes your family members and others help you with your healthcare needs. If there is someone in particular you wish for us to be able to talk with about your healthcare needs, please complete this form and sign it prior to leaving our office. Please return this form to the reception upon completion. This will allow us to communicate with someone you trust about your care and treatment. The amount and type of information that will be shared about you with the person you designate is shared in the careful discretion of your healthcare provider. Examples of how we share your information include talking with you about your care in front of anyone you bring with you into the exam room, talking with your adult child designated on this form to help with your medical bills, and responding to questions about your medications with the person you designate.

If you wish for anyone to receive a copy of your medical records, a different form called an Authorization to Disclose Protected Health Information must also be signed by you.

This office has permission to disclose information regarding my medical care to the following specific person(s):

_____ _____

_____ _____

_____ _____

This designation to share information to the individual(s) named above will remain in force until such time as I revoke it in writing.

I understand and have been provided with a Patient Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that this office reserves the right to change the notice and practices, but that prior to implementation, a copy of any revised notice will be provided.

I understand that I must revoke this consent in writing, except to the extent the organization has already taken action.

_____

Patient's Full Name

_____ _____

Signature of Patient or Legal Representative if minor Printed Name and Relationship to Patient

_____

Today's Date (Effective date of notice)

Contact Authorization

I hereby authorize Caring Hands Healthcare Centers to contact me regarding my care or the care of someone I am legally responsible for using text to my phone, email, or voice mail.

My phone number for text and/or voicemail is _____

My email address is _____

_____ (Signature) _____ (Date)

This authorization if effective until rescinded by the signatory or by Caring Hands Healthcare Centers

December 2020

Name:
Address:
City, State:
Zip Code:
Telephone:
Social Security #:
Date of Birth:
Chart Number:

Caring Hands Healthcare Centers, Inc.
P.O. BOX 1**992**
McAlester, OK 74502

Sliding Fee Eligibility Form

It is necessary for us to ask personal questions in order to give you a discount on our medical expenses. This information will be kept on file in our center in strict confidence You must verify your income at least once a year. Your yearly income tax return with a copy of your W-2 form, payroll check stubs covering the past two pay periods, or copies of your social security checks, or other checks you may receive will be sufficient proof. Your annual income will be used to calculate the level of your payment.

Today's Date: _____ Number of people living in your home? _____

Do you own or rent your home? ☐ Own ☐ Rent ☐ Live with Someone

Amount of Household Income?

You	Your Spouse	Your Children	Other Person	Total Family Income

Place of Employment?

You	Your Spouse	Your Children	Other Person

Do you have money in your savings account? $ _____
Do you have money in a checking account? $ _____

Do you have any rental property? Yes ☐ No ☐
Do you own stock or certificates? Yes ☐ No ☐

Do you receive any income from any source, including the following sources, and if so, how much?

Sources	You	Your Spouse	Your Children	Other Person	Total Sources
Social Security					
Rental Income					
Retirement Pension					
Royalty/Interest Income					
Other (Specify)					
Other (Specify)					
Other (Specify)					
Other (Specify)					

Do you have any type of insurance that will cover all or a portion of your medical expense? Yes, list below ☐ No ☐

Give Names, DOB, and SSN of all individuals living in the household.

Name:	Date of Birth:	Social Security Number:

I declare the above information is true and have given Caring Hands Healthcare Centers, Inc. permission to investigate any information given in this application. I understand that this information will be kept in strict confidence. I also understand that providing false information may disqualify me from receiving a discount and may jeopardize my status at CHHC and/or be punishable by law. I also understand that if my income should change that I am required to notify the receptionist on my next visit to the clinic.

Signature:	Date:	*Clinic Purpose Only* Income Code:

CHHC Staff Verification Signature _____ Date _____

Revised 11/20/2018

CARING HANDS
HEALTHCARE CENTERS

Advance Directive Consent Form

I acknowledge that Caring Hands Healthcare Centers, Inc. has provided me with written information concerning Advance Directives. I have checked the following:

____ I have provided the Center with a copy of my duly executed Advance Directive.

____ I will complete the "Advance Directive Interim Form" until I can provide the Center with a copy of my duly executed Advance Directive.

____ I would like more information about Advance Directives.

____ I do not desire any additional information about Advance Directives.

Patient/Guardian (print) _____ **Date** _____

Patient/Guardian Signature_____ **Date of Birth** _____