NEW Health

ADVANCE CONSENT TO TREATMENT OF A MINOR FOR MOBILE CLINIC

Child's Name: _____ **Birth Date:** _____

Address: _____

Telephone: _____ **Clinic:** _____

Check all that apply:

_____ I (we) hereby authorize the clinic listed above to provide surgical, medical, or dental treatment by any licensed healthcare provider for my (our) child listed above when such treatment is deemed necessary by such healthcare providers and I (we) cannot be reached within a reasonable time, by reason of absence from the community, or otherwise.

_____ I (we) hereby authorize _____ *(Name, Relationship)* to consent to any medical or dental treatment at the clinic listed above by any licensed healthcare provider for my (our) child listed above when such treatment is deemed necessary by such healthcare provider and I (we) cannot be available to accompany the child for care.

Such consent may include but is not limited to administration of necessary anesthetics, medical or dental treatment, tests, x-ray examinations, dental x-rays, transfusions, injections, drugs, dental fluoride application and the performance of whatever operations may be deemed necessary or advisable. Further, consent is granted to said healthcare provider to exercise his/her discretion in authorizing the disposal of any severed tissue or members.

It is understood this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide the authority to provide treatment which, in the exercise of best judgment of the involved healthcare providers, is deemed advisable.

Please choose:

☐ **I hereby authorize the use of fluoride varnish for my child or the individual to whom I am the legal guardian during their prophy cleaning and/or exam.**

☐ **I do not authorize the use of fluoride varnish for my child or the individual to whom I am the legal guardian during their prophy cleaning and/or exam.**

Check the paragraph below for services less than urgent or emergent:

_____ I (we) wish this authorization to include provision of routine (non-emergency) x-ray or laboratory tests ordered by my child's usual physician to be accomplished as an outpatient.

This authorization shall remain effective for **five** years unless revoked sooner in writing by the undersigned.

Parent/Guardian Signature: _____ **Date:** _____

Address (if different from child's): _____

Witness Signature: _____

Dental General Informed Treatment Consent

I understand and authorize the dentist and/or such associates or assistants as s/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an adverse reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek, or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription, over the counter, and/or recreational drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva, or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name:_____

Signature:_____ Date:_____

(Patient, parent/legal guardian, or authorized agent of patient)

Witness:_____ Date:_____

NEW Health

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems you may have, or medications you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

PATIENT NAME:	**DATE OF BIRTH** (M/D/Y): / /	**HEIGHT:**	****OFFICE USE****
		WEIGHT:	**BP:** **PULSE:**

No ❒ Yes ❒ Are you under a physician's care now? Physician's name and clinic:

Are you interested in receiving medical care from NEW Health Programs Association? Yes ❒ Seeing NEWHP Provider ❒ No ❒
If yes, how do you prefer to be contacted? ❒ Phone: ❒ Email:

No ❒ Yes ❒ Have you ever been hospitalized or had a major operation? *Please explain:*

No ❒ Yes ❒ Have you ever had a serious head or neck injury? *Please explain:*

No ❒ Yes ❒ Are you taking, or have you taken any medications for Osteoporosis? *When:* _____ *How Long:* _____
Are you, or have you taken any of the following? ❒ Fosamax ❒ Boniva ❒ Zometa
Taken: ❒ IV ❒ Oral ❒ Other:

No ❒ Yes ❒ Do you take a blood thinner (Coumadin, Warfarin, Xarelto, etc.)? *Last INR level:* *Date:*

No ❒ Yes ❒ Have you taken an antibiotic before a dental/medical procedure? Please explain:

No ❒ Yes ❒ Do you use tobacco? Type: ❒ Smoking ❒ Chewing ❒ Vaping *How much daily?* *When did you start?*

No ❒ Yes ❒ Do you use marijuana? Type: ❒ Smoke ❒ Edibles ❒ Other: *How much daily?* *When did you start?*

No ❒ Yes ❒ Do you have, or have you had a drug addiction: *What Drug(s):* *When:*

How many carbonated and/or sweetened beverages do you drink a day?

WOMEN: Are you pregnant and/or trying to get pregnant? No ❒ Yes ❒ *Due Date:* *Nursing:* No ❒ Yes ❒

Are you allergic to any of the following? ❒ Aspirin ❒ Penicillin ❒ Codeine ❒ Acrylic ❒ Metal ❒ Latex ❒ Local Anesthetic ❒ Other:

Do you have, or have you had, any of the following? *(Check the box on the left for all that apply)*

❒ ADHD/ADD	❒ Chemotherapy *When:*	❒ Heart Failure/CHF	❒ PTSD *Cause:*
❒ AIDS/HIV		❒ Heart Trouble/Disease	
❒ Angina/Chest Pain	❒ Chronic Pain	❒ Hepatitis *Type:* ☐ A ☐ B ☐ C	❒ Radiation Therapy *Where:* *When:*
❒ Arthritis	❒ Cold Sores/Herpes		
❒ Artificial Heart Valve	❒ Congenital Heart Disorder	❒ Hypoglycemia	❒ Renal Dialysis
❒ Artificial Joint(s) *Joints:* *When:*	❒ COPD	❒ Infective Endocarditis	❒ Rheumatic Fever
	❒ Depression	❒ Irregular Heartbeat	❒ Rheumatism
❒ Asthma ☐ *Use Inhaler* ☐ *From Childhood*	❒ Diabetes Type: ☐ 1 ☐ 2 *Last A1C Level*:	❒ Kidney Disease	❒ Schizophrenia
		❒ Liver Disease	❒ Shingles
❒ Autism	❒ Emphysema	❒ Lung Problems: *Explain:*	❒ Sickle Cell Disease
❒ Bipolar Disorder	❒ Epilepsy/Seizures *Type:* *How often:*		❒ Sinus Problems: *Explain:*
❒ Bleeding Disorder		❒ Methemoglobinemia	
❒ Blood Disease	❒ Fibromyalgia	❒ Mitral Valve Prolapse	❒ Sleep Apnea
❒ Blood Pressure - HIGH	❒ GERD/Acid Reflux/Ulcers	❒ Other Mental Illness *Type(s):*	❒ Stroke *When:*
❒ Blood Pressure - LOW	❒ Glaucoma		
❒ Cancer *Type:* *When:*	❒ Headaches/Migraines	❒ Pacemaker	❒ Thyroid Disease
	❒ Heart Attack *When:*	❒ Pain in Jaw Joint	❒ Tuberculosis
		❒ Parathyroid Disease	

Have you ever had any **SERIOUS** illness not listed above? No ❒ Yes ❒ *If yes, please explain:*

LIST MEDICATIONS ON BACK →

NEW Health

PATIENT NAME:	DATE OF BIRTH (M/D/Y): / /
PHARMACY:	

MEDICATIONS

Please list current prescription medications and vitamins/supplements/over-the-counter medications that you are currently taking, including those occasionally used.

Prescription Medications	Vitamins/Supplements/ Over-the-Counter Medications
❒ None	❒ None

To the best of my knowledge, the questions on this form have been accurately answered. I understand that not providing information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office on any changes in medical status.

SIGNATURE OF PATIENT or PARENT/GUARDIAN (if under 18):	DATE:
SIGNATURE OF PROVIDER	DATE:

NEW Health

REGISTRATION FORM (PLEASE FILL OUT COMPLETELY)

Patient Information			
LAST NAME:	FIRST NAME:	MI:	DOB: / /
PHYSICAL ADDRESS:			
MAILING ADDRESS:			
SOCIAL SECURITY #: N/A	Marital Status:	Preferred Pharmacy:	
Home #	Mobile #	Email:	
Preferred Contact Method: ☐Text ☐Email ☐Phone	Sex Assigned at Birth: ☐ Male ☐ Female		
Sexual Orientation: ☐Straight ☐Bisexual ☐ Lesbian or Gay ☐Don't know ☐ Other ☐ Choose not to disclose			
Gender Identity: ☐Male ☐Female ☐Other ☐ Transgender Male (Female-to-Male) ☐ Transgender Female (Male-to-Female) ☐ Choose not to disclose			
RESPONSIBLE PARTY *Complete if someone other than the patient			
Last Name:	First Name:	MI:	DOB: / /
Physical Address:			
Phone #	Email:	Relationship to Patient:	
MEDICAL INSURANCE INFORMATION			
Subscriber Name:	Relationship to patient:	DOB: / /	
Primary Medical Insurance:			
Member ID #	Group #	Effective Date: / /	
DENTAL INSURANCE INFORMATION			
Subscriber Name:		DOB: / /	
Primary Dental Insurance:			
Member ID #	Group #		

Data Survey- To comply with requirements regarding federal record-keeping & reporting, we ask that you complete the following data survey. YOUR COOPERATION IS APPRECIATED

Primary Language: ☐English ☐Spanish ☐ Other:		Interpreter Needed? ☐Yes ☐No
Family Size:	Estimated annual household income: $	Are you a Veteran? ☐Yes ☐No

Ethnicity	**Race**		**Special Population**
☐Hispanic (Latino)	☐White	☐Black (African American)	☐Migrant Worker
☐Non-Hispanic (Latino)	☐Asian	☐American Indian/ Alaska Native	☐Seasonal Worker
☐Unreported/ Refused	☐Native Hawaiian	☐Other Pacific Islander	☐Homeless
	☐Unreported	☐Multiracial- Select 2	☐Public Housing

Health Insurance Portability & Accountability Act (HIPAA)/ Privacy Policy & EMERGENCY CONTACT

Please list the names of persons authorized by you to receive your health information, pick up medication, or copies of personal paperwork.
Note: Photo ID and signature required by person picking up medications or copies of other information

Name:	**Phone #:**	**Relationship:** ☐ Parent/ Guardian ☐Spouse ☐ Other:
Name:	**Phone #:**	**Relationship:** ☐ Parent/ Guardian ☐Spouse ☐ Other:

****Please check each item below. Sign and date at the bottom****

ACKNOWLEDGEMENT AND AUTHORIZATION:

☐ I have read and understand the HIPAA/Privacy Policy for NEW Health.

Scan QR code to read the document:

☐ I have read and understand the Appointment Policy for NEW Health.

Scan QR code to read the document:

☐ I hereby assign my insurance benefits to be paid directly to NEW Health.

☐ I authorize NEW Health to release medical/dental information required to process my claim.

☐ I authorize NEW Health to obtain/have access to my medication, vaccine and health history.

☐ I authorize my provider's office to contact me by mobile phone, including text messaging.
We call or send texts/emails regarding your appointments, updates, surveys, and newsletters approximately 1-2 per week. You can change your contact preferences at any time either by text, email, online or by contacting the clinic. You are responsible for any text or data charges that may occur.

☐ I authorize NEW Health to mail or leave detailed messages regarding appointment and/or lab results with the individual answering my home number or voicemail system.

☐ I authorize my provider's office to obtain my photograph for proof of identity.

☐ I authorize that the information provided in the registration form is accurate.

How did you hear about us?

☐ **Facebook** ☐ **Radio** ☐ **Newspaper** ☐ **Referral** ☐ **Billboard** ☐ **Word of Mouth**

I certify that the information provided is correct.

Signature: _____ Date_____