Western Sierra Medical Clinic
Better Health Together

# Dental Patient Questionnaire

wsmcmed.org

**Patient Name: _____Date of Birth: _____Date:_____**

## Personal Medical History:

**Check yes or no to indicate whether you have had any of the following (*circle to add needed information*):**

| | | | | | |
|---|---|---|---|---|---|
| Yes ☐ | No ☐ | AIDS/HIV Positive | Yes ☐ | No ☐ | Heart problems/Heart Surgeries |
| Yes ☐ | No ☐ | ADD/ADHD | Yes ☐ | No ☐ | Hemophilia/Abnormal bleeding/Blood Disease |
| Yes ☐ | No ☐ | Anaphylaxis | Yes ☐ | No ☐ | Hepatitis A/B/C |
| Yes ☐ | No ☐ | Anemia | Yes ☐ | No ☐ | Herpes |
| Yes ☐ | No ☐ | Anxiety | Yes ☐ | No ☐ | High Blood Pressure |
| Yes ☐ | No ☐ | Arthritis, Rheumatism | Yes ☐ | No ☐ | Immunizations |
| Yes ☐ | No ☐ | Artificial joints (Hip/Knee/Shoulder) | Yes ☐ | No ☐ | Kidney disease or malfunction |
| Yes ☐ | No ☐ | Asthma | Yes ☐ | No ☐ | Liver disease |
| Yes ☐ | No ☐ | Atopic (allergy prone) | Yes ☐ | No ☐ | Material allergies (latex/wool/metal/chemicals) |
| Yes ☐ | No ☐ | Autism Spectrum | Yes ☐ | No ☐ | Neurological Disorders |
| Yes ☐ | No ☐ | Back problems | Yes ☐ | No ☐ | Radiation treatment |
| Yes ☐ | No ☐ | Blood disease | Yes ☐ | No ☐ | Rapid weight gain or loss |
| Yes ☐ | No ☐ | Cancer: _____ | Yes ☐ | No ☐ | Respiratory disease/COPD/Shortness of breath |
| Yes ☐ | No ☐ | Chemotherapy | Yes ☐ | No ☐ | Rheumatic/Scarlett fever |
| Yes ☐ | No ☐ | Circulatory problems | Yes ☐ | No ☐ | Shingles |
| Yes ☐ | No ☐ | Cortisone treatments | Yes ☐ | No ☐ | Spina Bifida |
| Yes ☐ | No ☐ | Cough up blood | Yes ☐ | No ☐ | Stroke |
| Yes ☐ | No ☐ | Cough, persistent | Yes ☐ | No ☐ | Surgical implant |
| Yes ☐ | No ☐ | Dementia | Yes ☐ | No ☐ | Swelling of feet or ankles |
| Yes ☐ | No ☐ | Depression | Yes ☐ | No ☐ | Thyroid disease or malfunction |
| Yes ☐ | No ☐ | Diabetes | Yes ☐ | No ☐ | Tobacco habit/Vaping/Chew |
| Yes ☐ | No ☐ | Dialysis | Yes ☐ | No ☐ | Tonsillitis |
| Yes ☐ | No ☐ | Epilepsy/Seizures | Yes ☐ | No ☐ | Tuberculosis |
| Yes ☐ | No ☐ | Fainting | Yes ☐ | No ☐ | Ulcer/Colitis |
| Yes ☐ | No ☐ | Glaucoma | Yes ☐ | No ☐ | Venereal disease/STD |
| Yes ☐ | No ☐ | Headaches/Migraines | Yes ☐ | No ☐ | Other Medical condition not listed: _____ |
| Yes ☐ | No ☐ | Heart murmur/Mitral Valve Prolapse | | | |

**Women:** Are you pregnant? Yes ☐ No ☐ Nursing? Yes ☐ No ☐ Taking Birth Control? Yes ☐ No ☐

## Bisphosphonate Intake/Osteoporosis Treatment:

Are you being treated for osteoporosis (pills, injections, or any other type)? Yes ☐ No ☐

If yes, name of medication and/or treatment: _____

Date of last intake and/or treatment: _____-

Physicians Name: _____Phone: _____Date of last visit: _____

## Personal Dental History:

Please indicate your chief concern: _____

Are you in dental discomfort today? Yes ☐ No ☐

Please check yes or no if you have or have had problems with any of the following.

| | | | | | |
|---|---|---|---|---|---|
| Yes ☐ | No ☐ | Bad breath | Yes ☐ | No ☐ | Periodontal treatment |
| Yes ☐ | No ☐ | Bleeding gums | Yes ☐ | No ☐ | Sensitivity to cold |
| Yes ☐ | No ☐ | Clicking or popping jaw/pain | Yes ☐ | No ☐ | Sensitivity to hot |
| Yes ☐ | No ☐ | Food collection between teeth | Yes ☐ | No ☐ | Sensitivity to sweets |
| Yes ☐ | No ☐ | Grinding or clenching teeth | Yes ☐ | No ☐ | Sensitivity when biting |
| Yes ☐ | No ☐ | Loose teeth or broken fillings | Yes ☐ | No ☐ | Sores or growths in mouth |

How often do you brush? _____How often do you floss? _____

How do you feel about the appearance of your teeth? _____

Have you experienced an adverse reaction during/in conjunction with a medical or dental procedure? Yes ☐ No ☐

If so, explain: _____

Other information about your dental health or previous treatment: _____

_____

List current medications: _____

_____

List all known allergies: _____

_____

List hospital visits/surgeries: _____

_____

Do you use any drugs, such as marijuana (cannabis), cocaine, heroin, etc.?

| Name | Past Use | Currently Using |
|---|---|---|
| | | |
| | | |
| | | |

_____ **(Patient initials)** I have received a copy of the Dental Materials Fact Sheet as required by law.

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

_____ _____ _____

Print Patient or Parent/Guardian Name | Patient or Parent/Guardian Signature | Date

Western Sierra Medical Clinic
Better Health Together

# Patient Registration Form

☐ New Patient ☐ Update ☐ WH/OB
☐ UC ☐ Dental ☐ Teen

www.wsmcmed.org

| *PATIENT INFORMATION* | | | |
|---|---|---|---|
| First Name | Middle Name | Last Name | Other Name |
| Physical Address | City | State | Zip |
| Mailing Address | City | State | Zip |
| Home Phone ☐ Text Enabled | Work Phone | Cell Phone ☐ Text Enabled | |
| ☐ I give WSMC permission to leave detailed messages concerning my care on my voicemail. Number: | | | |
| Date of Birth | Social Security # | Email Address ☐Create Patient Portal Account | |
| Emergency Contact | Emergency Contact Phone | Relationship to Emergency Contact | |
| Name of Father/Guardian: | | Name of Mother/Guardian: | |
| Is anyone else authorized to bring your child in for a visit? If so, Name and Relationship to Patient: _____<br>Does this person have legal authority to consent to treatment and receive protected health information pertaining to your child?<br>☐ Yes ☐ No | | Is there anyone with whom you want us to share protected health information pertaining to your child? If so, Name and Relationship to Patient: | |
| Patient Race:<br>☐ Asian Indian ☐ Korean ☐ Other Pacific Islander ☐ American Indian/Alaska Native<br>☐ Chinese ☐ Vietnamese ☐ Guamanian or Chamorro ☐ White<br>☐ Filipino ☐ Other Asian ☐ Samoan ☐ Unreported | ☐ Japanese ☐ Native Hawaiian ☐ Black/African American | | Patient ethnicity:<br>☐ Hispanic or Latino<br>☐ Not Hispanic or Latino<br>☐ Refused to Report |
| Sexual Orientation:<br>☐ Lesbian or Gay ☐ Straight (not lesbian or gay) ☐ Bisexual<br>☐ Something else ☐ Choose not to disclose ☐ Don't know<br>Birth Sex: ☐ Male ☐ Female | | Gender Identity:<br>☐ Male ☐ Female ☐ Transgender Male to Female<br>☐ Transgender Female to Male<br>☐ Choose not to disclose ☐ Other | |
| Are you a Veteran?<br>☐ Yes ☐ No | Are you a migrant farm worker?<br>☐ Yes ☐ No | Are you homeless?*<br>☐ Yes ☐ No | How did you hear about WSMC? |
| Primary Language | Family Size (household) | Annual Income (household) | |
| Date of Injury/Onset of Illness: | Are you here for an automobile accident? ☐ Yes ☐ No | Are you here for a work-related injury or illness?<br>☐ Yes ☐ No | Are you pregnant?<br>☐ Yes ☐ No |
| Please explain the reason you are here today: | | | |
| Primary Care Provider (PCP):<br>Note: You must follow up with your PCP after each urgent care visit | | Primary Care Provider Phone | |

*To be considered homeless, you must fit into one of the following categories:
- Lacking a regular, adequate place to sleep at night.
- Losing your primary nighttime residence within 14 days and not having an alternative.
- Being an unaccompanied youth under 25 or part of a family with children who qualify under other Federal statutes.
- Fleeing domestic violence and lacking permanent housing resources or support networks.

| *GUARANTOR – PERSON RESPONSIBLE FOR PAYMENT* | | | |
|---|---|---|---|
| o Mr. o Mrs. o Miss Last Name | First Name | Middle | Relationship to Patient | Home Phone ( ) |
| Billing Address (if different from Patient's) City | | State | Zip Code |
| Employed By | Job Title/Department | Work Phone Ext. # ( ) ( ) |
| Employer Address (Number and Street) | Guarantor's Social Security # -- -- | Guarantor's Date of Birth |
| City | State | Zip Code |

| *PRIMARY INSURANCE INFORMATION* | | |
|---|---|---|
| Insurance Company | Policy Number | Group Number |
| Subscribers First Name | Subscribers Middle Name | Subscribers Last Name |
| Date of Birth | Social Security # | Employer |

| *SECONDARY INSURANCE INFORMATION* | | |
|---|---|---|
| Insurance Company | Policy Number | Group Number |
| Subscribers First Name | Subscribers Middle Name | Subscribers Last Name |
| Date of Birth | Social Security # | Employer |

| *PHARMACY CHOICE* |
|---|
| ☐ WSMC Pharmacy Located at 844 Old Tunnel Road in Grass Valley |
| ☐ Other: Pharmacy Name:_____ City: _____ |

| *CONSENT FOR MEDICAL TREATMENT* |
|---|
| The undersigned, as the above patient or as the parent, legal guardian or legal representative of the above patient, hereby consents to medical treatment of the above patient by Western Sierra Medical Clinic (WSMC) and its medical providers and clinical staff. Treatment may include any necessary examination, test or medical procedure a WSMC medical provider in the exercise of his/her best judgment may deem advisable for the above patient to be performed by WSMC clinical staff. I understand and acknowledge this authorization is given in advance of any specific diagnosis, treatment or procedure being required to provide specific consent to any and all such diagnosis, treatment or procedure a WSMC medical provider in the exercise of his/her best judgment may deem advisable for the above patient.<br><br>I understand the above patient may ask questions and have all questions answered and also may refuse treatment at any time.<br><br>If the above patient is seeking substance abuse testing, I authorize WSMC to obtain a specimen pursuant to proper medical protocol to determine the presence of drugs or alcohol.<br><br>I understand that some physical exams (like fitness for duty, school, or sports) and other services are not intended to diagnose medical conditions or replace the medical care of the above patient's personal physician. |

*HEALTH INFORMATION EXCHANGE*

Electronic Health Information Exchange (HIE) allows doctors, nurses and other health care providers to access and securely share a patient's vital medical information electronically, improving the speed, quality, safety and cost of patient care. Electronic health information systems can help prevent errors by ensuring that everyone involved in a patient's care—whether in a primary care setting, a specialists' office or emergency department—has access to the same information. HIE helps facilitate coordinated patient care, reduce duplicative treatments and avoid costly mistakes. This practice is growing among health providers because the need for HIE is clear and the HIE benefits are significant.

By default, all patients are "Opted In" in the HIE, meaning that once notified of the HIE, a patient must complete an Opt Out form if they do not wish to participate. A patient's health information will be available to all of the providers in the system who need it to provide care WITHOUT having to sign any further forms. Please see the receptionist if you would like a copy of this form or would like to request a change to your HIE options.

*TELEMEDICINE*

At WSMC, we offer telemedicine services as a convenient way to receive medical care through phone or video consultations. This method is cost-effective, saves time, reduces transportation barriers, and improves access to healthcare. Studies have also shown that telemedicine can improve the quality of healthcare.

However, it's important to note that telemedicine does have limitations. Telemedicine requires adequate privacy, technology, and service to conduct phone calls or video visits. In some circumstances, it may not be appropriate for conditions that require a physical examination.

Telemedicine visits costs can vary by insurance, however, the visit cost for telemedicine is no more than a standard office visit. You have the right to request more information about our telemedicine services. You may deny telemedicine visits and request an in-office consultation at any time during the scheduling process.

*FINANCIAL RESPONSIBILITY*

It is the patient's responsibility, and the responsibility of a patient's parent/legal guardian, to pay their share of charges for services provided by WSMC at the time of service, unless other arrangements are made in advance in writing signed by the patient and an authorized WSMC staff member. Payment of a patient's share can be in the form of insurance copays, deductibles, or cash payment for uninsured patients and cash pay patients. Patients not enrolled in health plans are responsible to pay for the entire amount of their bill. Patients enrolled in health plans are responsible for any amount the plan does not pay, up to the entire amount.

WSMC accepts cash, checks, and most major credit cards. A $25.00 fee will be charged for the first check returned by the bank and a service fee of up to $35 for each subsequent check returned by the bank to that same payee.

WSMC does not accept liens or other forms of promised payments for patients who are involved in work-related or personal injuries (e.g., automobile accidents). Patients pursuing claims for work-related or personal injury should consult with their employer and/or the appropriate insurance company for health care needs. WSMC will provide primary care services to a patient pursuing these claims as requested by the patient, but the patient remains responsible to pay for all such services in full. WSMC will not bill workers compensation, automobile or other similar insurance company.

*IDENTITY AND INSURANCE VERIFICATION*

Patients are required to provide WSMC with correct insurance information and to verify current personal information (home address, employer, phone number, insurance cards, and photo ID) at the each appointment check-in. <u>It is important that you bring proof of insurance each time you visit. Failure to do so may result in you not being seen or being required to make a full payment at the time services are rendered.</u>

*WILLINGNESS TO PAY*

No one will be denied services at WSMC due to inability to pay as long as there is a "willingness" to pay. Willingness to pay means either paying for services rendered (either through insurance with payment of patient copays and deductibles, cash pay, sliding fee scale) or a commitment to follow a written payment plan in order to pay off any outstanding balance in accordance with WSMC's policies and procedures.

An unwillingness to pay is demonstrated by a patient when the patient refuses to pay for services rendered (including copays, deductibles, and fees owed under the sliding fee scale discount program), refuses to commit to a written payment plan, or refuses to comply with a written payment plan signed by the patient.

Uninsured Patients needing financial assistance to pay for services should fill out a sliding fee scale application (see below) and may seek assistance from staff.

If a patient signs a written payment plan and has difficulty making payments under the plan, WSMC's Billing Department Supervisor is available to discuss amending the payment plan.

*SLIDING FEE*

For patients who qualify, a sliding scale discount may be applied to a patient's initial primary care, dental or behavioral health visit and for visits over the following six months. Patients who desire to apply for a sliding fee discount are required to complete an application, which explains WSMC's sliding fee scale discount program. Please ask a WSMC Billing Department staff member for the application and for an answer to any question regarding the sliding fee scale discount program.

*ASSIGNMENT OF BENEFITS*

I hereby irrevocably assign and/or convey directly to Western Sierra Medical Clinic, Inc. and/or its contracted healthcare providers (hereinafter "WSMC"), as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by WSMC for treatment/services rendered by WSMC, regardless of its managed care network participation status. This Assignment of Benefits shall apply to all insurance coverage, including but not limited to the Centers for Medicare and Medicaid Services, its intermediaries, carriers or administrative contractors, State Medicaid programs, or any other governmental or commercial insurance. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. This assignment is valid until revoked in writing. A photocopy of this assignment is to be considered valid, the same as if it was the original.

*ACKNOWLEDGEMENTS*

1. WSMC's notices, policies, and procedures are subject to change without notice. By receiving services at WSMC, I am subject to those changes unless I indicate in writing that I do not accept the changes. I may request copies of the current notices, policies and procedures.
2. WSMC's Notice of Privacy Practices is posted in the lobby of each WSMC facility and on the WSMC website. A copy can be furnished to me upon request. I read and understand WSMC's Notice of Privacy Practices.
3. WSMC's Patient Rights and Responsibilities is posted in the lobby of each WSMC facility and on the WSMC website. A copy can be furnished to me upon request. I read and understand WSMC's Patient Rights and Responsibilities.
4. As a patient of WSMC, I have access to a medical provider 24 hours a day, seven days a week.
    a. To access a medical provider after hours, call (530) 274-9762.
5. I may voice any concerns or grievances by contacting WSMC's Patient Advocate at (530) 274-9762 ext. 251.
6. I may not record, photograph or videotape inside a WSMC site.
7. I am solely responsible for safeguarding and protecting my personal property. WSMC is not responsible for safeguarding or for the theft, loss or damage to my personal property. I release all claims against WSMC for loss, theft or damage to my personal property.

*SIGNATURE*

I have read this form or have had it read to me in a language I can understand. I have had my questions about this form answered.

_____

Signature or person giving consent or legal representation Date

Print Name: _____

Relationship to Patient: □ Self □Parent □Guardian □Authorized Representative

Western Sierra Medical Clinic does not discriminate on the basis of race, color, national origin, age or disability, ethnicity, religion, culture, language, sex, physical or mental disability, socioeconomic status, sexual orientation, or gender identity or expressions

# Patient's Rights and Responsibilities



Western Sierra Medical Clinic (WSMC) is committed to providing quality of care to our clients and their families. We encourage patients to be aware of their rights and responsibilities as listed below:

## You Have the Right to:

1. Receive considerate, respectful, and culturally appropriate care based on professional standards of practice.
2. Receive services without discrimination on the basis of race, color, sex, marital status, religion, age, handicap, sexual orientation or preference, national origin, ancestry or diagnosis.
3. Establish advance directives and participate in ethical decision making.
4. Receive an explanation of your diagnosis, treatment, and prognosis in terms and language you can understand.
5. Receive the necessary information to participate in decisions about your care and to give your informed consent before any diagnostic or therapeutic procedure is performed.
6. Refuse any treatment, except as prohibited by law, and to be informed of the consequences of making this decision, which may include informing Children, Youth, and Family Services or Protective Services.
7. Expect that your personal privacy will be respected by all staff.
8. Expect that your medical records will be kept confidential and information will be released only with your written consent, in cases of medical emergencies, or in accordance with law.
9. Know WSMC policy for accessing and disclosing information in your medical records and reviewing your medical record, upon request, at a mutually designated time.
10. Receive a full explanation of any research or experimental procedure proposed for treatment and the opportunity to give your informed consent before any procedure will begin.
11. Know the name and qualification of all individuals providing service and how to contact that person.
12. Obtain another medical opinion prior to any procedure.
13. Have your legal custodian access your written medical records by appointment.
14. Ask for and receive information on your financial liability and an explanation of charges, including services that will be charged to your insurance.
15. File a complaint about services rendered without fear of discrimination from Western Sierra. Please call our Office Manager at (530) 274-9762 between 8:30 a.m. and 4:30 p.m.

Western Sierra Medical Clinic does not discriminate on the basis of race, color, national origin, sex, age or disability, ethnicity, religion, culture, language, sex, physical or mental disability, socioeconomic status, sexual orientation, or gender identity or expressions.

## You are Responsible for:

1. Providing accurate personal, financial, insurance and medical information, including all medications and treatments, necessary to establish and follow your plan of care.
2. Asking questions if you do not understand the explanation of your diagnosis, treatment, prognosis or any instructions.
3. Informing WSMC of any requirements or accommodations needed to meet your cultural and/or language needs.
4. Following rules and regulations that are posted within WSMC while in the facility.
5. Not carrying any type of weapons when receiving treatment.
6. Not harming or being abusive to other persons including WSMC staff.
7. Keeping all scheduled appointments, arriving on time, and being able to participate in treatment.
8. Notifying WSMC with 24 hours' advance notice or as soon as you are aware that you cannot keep an appointment.
9. Informing WSMC health care professionals regarding any changes or reactions to medication and/or treatment.
10. Paying for services promptly including co-payments and total of cash charges at the time of service.
11. Advising WSMC of any problems or dissatisfaction with the service being provided.
12. Extending to WSMC staff the same courtesy given to you.
13. Developing and participating in your treatment planning.
14. Providing for the supervision and safety of your children while in the facility.
15. Keeping WSMC apprised of your current contact information.
16. Not videotaping or recording any WSMC staff.

Western Sierra Medical Clinic
Better Health Together

# Release of Health Information

844 Old Tunnel Rd.
Grass Valley CA, 95945
wsmcmed.org

| | | | | |
|---|---|---|---|---|
| 1 | Patient's Last Name | | Patient's First Name | Date of Birth |
| 2 | ☐ Please release information/send records FROM WSMC* (To Person/Facility Below) ☐ Please release records TO WSMC (From Person/Facility Below)<br>*Transferring your primary care outside of WSMC may delay your appointment for specialty care. | | | |
| 3 | Full Name of Organization/Provider/Individual (or Self) | | | |
| | Address | | | City |
| | State | Zip | Phone # with area code | Fax with area code |
| | Transmit:<br>Verbally □ Electronic: □ Fax □ U.S. Mail: □ CD □Paper | | | |
| 4 | CHOOSE ONLY ONE (1) Per Release<br>____Medical ____HIV/AIDS Testing & Treatment ____Alcohol/Substance/Drug Use Treatment<br>____Dental ____Behavioral Health ____ Psychotherapy Notes ____Other: | | | |
| 5 | Time Frame: ☐Last Visit ☐Past Year ☐All ☐Other: | | | |
| 6 | ☐All records ☐Just these: | | | |
| 7 | Reason for release: ☐Personal ☐Transfer of Care ☐Other: | | | |
| Authorization | By signing, I authorize use/disclosure of my health information and understand that:<br>• I may revoke this authorization at any time by contacting WSMC in writing.<br>• This authorization is valid for 1 year maximum or this earlier date: ____ / ____ / ____.<br>• The recipient of your health information may not further disclose your information without obtaining another authorization from you.<br>• All Alcohol & Substance Abuse health information is protected and only releasable with a separate express written consent of the person it pertains to.<br>• My treatment/eligibility of care is not based on this authorization.<br>• This authorization is voluntary and a photocopy or fax of this authorization is as valid as the original<br>• I have the right to a copy of this authorization. | | | |

SECTIONS 1-7 MUST BE COMPLETED TO BE VALID

Signature

_____Date: ____ / ____ / ____ Tel: (_____)_____ - _____

If not patient: ☐Patient's Representative

Print Name and State Relationship: _____

RECEIVED BY:

PLEASE WRITE CLEARLY OR WE WILL NOT BE ABLE TO PROCESS THIS REQUEST.

Western Sierra Medical Clinic does not discriminate on the basis of race, color, national origin, sex, age or disability, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sexual orientation, or gender identity or expressions.