Samaritan Dental Clinic

Date ____/____/____

Patient Information Form

Please answer the following questions

First Name _____ MI _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work/Message Phone _____Cell_____

Gender Male _____ Female _____ Date of Birth ____/____/____ Age _____

Race/Ethnicity White _____ Black _____ Hispanic _____ Asian _____Marshallese_____ Other _____

Marital Status Single _____ Married _____ Separated _____ Divorced _____

Emergency Contact Name _____Phone _____ Relationship _____

Number in household Adults _____ Children under 18 _____

Financial Information

Are You Employed? Yes____ No _____Employer Name _____
Are any other members of your household employed? Yes _____ No____ Employer _____
Do you have a Commercial Medical Insurance? Yes ____ No ____ Commercial Dental Insurance? Yes___ No___
Name of Insurance Company (S) _____
Do you have Medicare? Yes ____ No ____
Do you have Medicare SSI (Supplemental Security Income)? Yes___ No_____

Do you have a Supplemental Medicare (Advantage Plan) Yes____ No _____
If so, which one: Humana Coventry_____ Advanta___BCBS____ Care Improvement Plus____Wellcare____Tribute___

If no Medicare Do you have Arkansas Medicaid? Yes_____ NO____
SSI_____TB Medicaid _____Breast Care_____ Family Planning_____

Monthly Household Income: *** Please fill out all Information fields ***

Your salary	$_____	Employer _____
Spouse's salary	$_____	Employer _____
If minor, parents' salary	$_____	Employer _____
Disability	$_____	
SSI (Supplemental Security Income)	$_____	Child support; alimony $_____
Unemployment	$_____	Other income $_____

Total Household Income $_____

Have any other members of your household had an appointment with Samaritan Dental Clinic before? Yes___ No___
Have you been through our Market (food pantry) before? Yes_____ No_____
Have you visited our Cafe Yes__ No___ Does your family utilize our Snackpacks for kids program? Yes__ No__

Samaritan Dental Clinic

Dental Questionnaire

Patient's Name: _____ Date of Birth: _____
Today's Date: _____

Medical doctor's name: _____Phone: _____
Preferred Pharmacy: _____
Any Pre-medication required: _____

Current Medications, including over the counter:

Medication	Dosage	Frequency	How long	Condition Being Treated

Please check if you CURRENTLY HAVE and/or HAVE HAD in the past, any of the following conditions or treatment:

- ☐ Allergies Type: _____
- ☐ Anemia
- ☐ Anxiety/Depression
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ AIDS/HIV Positive
- ☐ Auto Immune Disorder or taking an Immunosuppressant
- ☐ Back Problems
- ☐ Bisphosphonate Therapy Oral ___ (for osteoporosis) or IV_____ Date(s) Taken_____
- ☐ Blood Disease
- ☐ Blood Transfusion/Problems
- ☐ Cancer/Type _____ Date _____
- ☐ Chemotherapy
- ☐ Circulation Problems
- ☐ Congenital Heart Defect
- ☐ Cough, Chronic
- ☐ Diabetes Type 1 or 2 (circle which Type)
- ☐ Emphysema/Shortness of breath
- ☐ COPD
- ☐ Epilepsy/Seizure Disorder
- ☐ Fainting
- ☐ Food Allergies
- ☐ Hay Fever/Sinus Trouble
- ☐ Headaches/Frequent
- ☐ Headaches/Migraines
- ☐ Heart Attack/Heart Surgery Date: _____
- ☐ Heart Problems Describe: _____
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis (A, B, or C)Date of Diagnosis_____
- ☐ Herpes A-oral
- ☐ High Blood Pressure
- ☐ Kidney Disease/Problems
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Sexually (Venereal) Transmitted Disease
- ☐ Stroke Date: _____
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Other

Known Allergies:

- ☐ Any Metals
- ☐ Silver
- ☐ Aspirin
- ☐ Codeine
- ☐ Hydrocodone
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetics
- ☐ Penicillin
- ☐ Other Antibiotic: _____
- ☐ Sulfa
- ☐ Other:_____

What happens:

_____

_____

Check if you have had any problems with the following:

- ☐ Bleeding/Sensitive Gums
- ☐ Clicking/Popping Jaw
- ☐ Grinding/Clenching Teeth
- ☐ Lost or Broken Fillings
- ☐ Sensitivity to: Cold/Hot/Sweets
- ☐ Sensitivity to Biting
- ☐ Swelling
- ☐ Sores in Mouth

For Women Only:

- ☐ Pregnant
- ☐ Breast-Feeding
- ☐ Taking Birth Control Pills

How long has it been since you have been to the dentist Between: 0-2Years_____2-5 YRS____ 5-10YRS ___10+ YRS….

Have you been in contact with someone who has COVID-19 or who is being evaluated for COVID-19? Yes__ No___
Have you been out of the country in the past 14 days yes ___No___

Have you ever had a bad dental experience? Yes_____ No_____
If yes, please explain:

_____

_____

Do you use tobacco products? Yes _____ No _____
If yes, what form, how much, and for how long?

_____

Have you used any recreational drugs such as Marijuana or Methamphetamine within the past 24 hours? _____

What is the reason for today's visit?

_____

Authorization:
I have reviewed the information and answered all questions to the best of my knowledge. I understand this information will be used to determine the dental treatment I receive at this office and may be shared with other medical offices only as necessary. I will notify the office should any information change in the future.

Signature of Patient, or Parent if minor: _____

STAFF USE ONLY

Date_____	No change*_____	Changes noted on form*_____	Patient Initials_____
Date_____	No change*_____	Changes noted on form*_____	Patient Initials_____
Date_____	No change*_____	Changes noted on form*_____	Patient Initials_____
Date_____	No change*_____	Changes noted on form*_____	Patient Initials_____
Date_____	No change*_____	Changes noted on form*_____	Patient Initials_____

*to be initialed by the assistant, hygienist or dentist reviewing the health history with patient

Reviewed by: _____

Samaritan Dental Clinic
1211 West Hudson Road | Rogers, AR 72756 | (479) 636.4198 (o)

Notice to Patients with Regards to Medical History

Having a complete medical history is a key factor in helping us provide the necessary standard of care. All patients must provide an accurate and up to date medical history for the doctor to review. In the event that there is a medical condition that is complex, we may be unable to perform certain dental procedures, as certain conditions fall outside the scope of services we are able to provide. If this is the case, information on other possible medical resources in the area will be provided.

Your signature acknowledges your receipt and understanding of this requirement.

Patient Signature_____

Date_____

1211 West Hudson Road | Rogers, AR 72756 | (479) 636.4198 (o)

Samaritan Dental Clinic Patient Compliance Form

Samaritan Dental Clinic is a group of staff and volunteer dentists and hygienists, providing free dental health care to low income patients. Due to the volume of patients that need our services it is imperative that a patient comply with the appointment policies and recommended treatment plan or protocol, suggested by the Dental Clinic, Dentist (s), and Hygienist (s), especially with regard to home care and oral hygiene in order to continue treatment. The Dental Clinic reserves the right to dismiss a patient for non-compliance with any policies.

The Dental Clinic also reserves the right to dismiss a patient for non-compliance with attendance in regards to broken appointments. It is considered a broken appointment when a patient calls to cancel less than 24 hours before the scheduled appointment time.

If for any reason you cannot make your appointment, you must call us no less than 24 hours prior to the scheduled appointment time to cancel or reschedule. . If a patient fails to show up for a scheduled appointment one (1) time, without prior notification, he/she will not be scheduled for further appointments

If and any time the staff Dentist or volunteer dentist feels that the patient is non-compliant, the staff Dentist reserves the right to discontinue treatment or dismiss the patient.

Samaritan Dental Clinic reserves the right to dismiss a patient for non-compliance at any time if the patient is disrespectful and or inappropriate to dental staff and or other clients/patients.

I have read these statements and understand that it is my responsibility to follow any instructions given to me by the SHC dental health care professionals and staff.

_____ _____

Patient Signature Date

_____ _____

Staff Dentist Signature Date

Samaritan Dental Clinic

Dental Treatment Consent Form

I hereby authorize and direct the provider, and whomever he/she may designate as his/her assistants, to administer such treatment as necessary. If unforeseen occurrences arise, the dentist or physician will use his/her judgment to manage the treatment in the most appropriate manner. This may include additional procedures.

I also certify that no guarantee or assurance has been made as to the results that may be obtained. I recognize the possibility of post-operative/treatment problems, most of which involve minor discomfort, but may also include more significant risks or damage. In any case that I do experience post-operative/treatment discomfort, I understand that it is the policy of the Samaritan Dental Clinic to evaluate me in person before I am prescribed additional, if any, medication. _____ (initial here)

I also certify that I am aware that a volunteer healthcare / dental professional may be rendering voluntary dental services for my treatment and that he / she is registered / covered under the Arkansas HealthCare Professional Immunity Act, and that he/she is immune from civil suit, and as a volunteer does not receive reimbursement or compensation for their voluntary services.

I also certify that that I am aware that all professional health care providers providing services have a current professional license or are under the supervision of a person who is licensed in the health care profession for which the student is seeking a degree, a license, or a certification

I also certify that I am aware that Samaritan Dental Clinic services are free of charge, the clinic does not bill to insurance, and / or receive reimbursement from insurance.

For the purpose of dental assistant education, I consent to the admittance of observers in the treatment rooms (patient has the right to decline observers during the visit).

I also certify that I have read and fully understand the above authorization for dental treatment.

_____

Patient Signature Date

Samaritan Dental Clinic
1211 West Hudson Road | Rogers, AR 72756 | (479) 636.4198 (o)

Samaritan Dental Clinics Patient Disclosure Form

Samaritan Health Clinics (SHC) is a group of staff and volunteers providing dental care to low income patients. The staff and volunteer dentists, oral surgeons, and other licensed health care professionals are exempt from malpractice suits under the Volunteer Licensed Health Care Professionals Immunity Act/ Act 276 of 1997 and the Retired Physician Immunity Act/Act 844 of 1995.

SHC provides dental services and recommended treatment. Patients are also referred to other service providers available within the community. Any and all referral service providers are also exempt from malpractice suits under the Volunteer Licensed Health Care Professionals Immunity Act/ Act 276 of 1997 and the Retired Physician Immunity Act/Act 844 of 1995.

SHC is not equipped to handle certain serious needs that may require hospitalization, outpatient surgery, or emergency room treatment. Additionally, a patient may be referred to the private office of the volunteer licensed dentist, oral surgeon, other area clinics.

Due to the volume of patients that need our services, we have a very strict no show policy. If a patient fails to show up for a scheduled appointment one (1) time, without notification / speaking to our clinic staff to cancel the appointment, he/she will not be scheduled for further appointments.

I have read these statements and understand that it is my responsibility to follow any instructions given to me by the SHC dental and health care professionals and staff.

_____ _____
Patient Signature Date

_____
Print SHC Staff or Volunteer Name

_____ _____
SHC Staff or Volunteer Signature Date

Samaritan Dental Clinic

Authorization to Release Personal Protected Health Information to an Individual

Patient Full Name: _____

Patient Date of Birth: _____

o ***I do not authorize*** the release of any dental information to *any individual* except for treatment and health care operations as specified in **Samaritan Dental Clinic's** Notice of Privacy Practices.

o ***I hereby authorize*** the release and disclosure of my dental information to the following individuals. My authorization extends to all protected health information for general information purposes. The information that may be discussed includes but is not limited to: records of all visits, records of visits for any and all dates, copies of records or reports provided to specialists, progress notes and consultation reports. I understand this authorization does not expire unless otherwise noted below.

(Please list the name of the individuals with whom we may discuss your protected dental information.)

Name	Relationship to patient

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy of fax of this authorization is as valid as the original.
3. I may revoke this authorization at any time, except where information has already been released. The revocation must be in writing. A revocation form is available from the receptionist.
4. This authorization will expire 1 year from the date of the signature.
5. Samaritan Dental Clinic, its employees, officers, and dentist are hereby released from any legal responsibility or liability for disclosure of the above information to the extent of indicated and authorized herein.
6. Treatment, enrollment or eligibility for benefits may not be conditioned upon obtaining this authorization.
7. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

Patient's Printed Name

_____

Patient's Signature

_____

Samaritan
COMMUNITY CENTER

P.O. Box 939 Rogers, AR 72757 Phone – 479-636-4198

Release Form for Media Recording

I, the undersigned, do hereby consent and agree that Samaritan Community Center/Samaritan Shop have the right to take photographs, videotape, or digital recordings of _____ and to use these in any and all media, now or hereafter. I further consent that my name and identity may be revealed therein or by descriptive text or commentary.

I do hereby release to Samaritan Community Center/Samaritan Shop all rights to exhibit this work in print and electronic form publicly or privately and to market and sell copies. I waive any rights, claims, or interest I may have to control the use of my identity or likeness in whatever media used.

I understand that there will be no financial or other remuneration for recording me, either for initial or subsequent transmission or playback.

I also understand that Samaritan Community Center is not responsible for any expense or liability incurred as a result of my participation in this recording, including medical expenses due to any sickness or injury incurred as a result.

I represent that I am at least 18 years of age, have read and understand the foregoing statement, and am competent to execute this agreement. If under the age of 18 a parent or guardian must sign.

Patient Accepts Media Release:

Patient Signature : _____Date: _____

Patient Declines Media Release :

Signature: _____Date_____

Samaritan Dental Clinic

Acknowledgement of Receipt of Privacy Notice

By signing this form, you are agreeing that you have received a copy of the Samaritan Dental Clinic Notice of Privacy Practices.

_____ _____

Patient Signature Date

++
++

STAFF USE ONLY

We provided the Notice of Privacy Practices to the individual above /patient. Written acknowledgement could not be obtained because:

____ An Emergency prevented us from obtaining acknowledgement

____ A Communication barrier prevented us from obtaining acknowlegement

_____ Patient or representative declined to sign the Acknowledgement of Receipt

_____ Other (please specify) _____

_____

_____

Printed Name of SDC Staff Member or Volunteer

_____ _____

Signature of SDC Staff Member or Volunteer Date

Samaritan Dental Clinic

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice is provided on behalf of the Samaritan Health Clinic.

PURPOSE: This Notice of Privacy Practices describes how we may use your Protected Health Information to carry out treatment, payment or healthcare operations and for other purposes permitted or required by law. “Protected Health Information” is information that may identify the patient and that relates to the patient's past, present or future physical or mental health, and may include name, address, phone numbers, and other identifying information.

We are required to give you this Notice and to maintain the privacy of your Protected Health Information. We must abide by this Notice, but we reserve the right to change the privacy practices described in it. A current version of this Notice, with required revisions, if any, may be obtained by sending a written request to the Samaritan Health Clinic, HIPAA Officer, 1211 West Hudson Road, Rogers, AR 72756.

We understand that medical information about you and your health is personal and confidential, and we are committed to protecting the confidentiality of your medical information. We create a record of the care and services you receive. We need this record to provide services to you and to comply with certain legal requirements. This Notice will tell you about the ways we may use and disclose your information. We also describe your rights and certain obligations we have to use and disclose your health information.

If you believe your Privacy Rights have been violated, you may complain to us or to the U.S. Secretary of Health and Human Services. To file a complaint with us, you may send a letter describing the violation to the clinic HIPAA Office, Samaritan Health Clinic, 1211 West Hudson Road, Rogers, AR 72756. There will be no retaliation for filing a complaint.

If you have questions or need more information, contact the clinic HIPAA Officer at (479) 636-4198.

WHO WILL FOLLOW THIS NOTICE: The Notice describes the practices of the Samaritan Health Clinic healthcare professionals, employees, volunteers and others who work or provide healthcare services.

ACKNOWLEDGEMENT: You will be asked to sign an Acknowledgement of receipt of this Notice. The delivery of your healthcare services will in no way be conditioned upon the signing of this Acknowledgement.

Your Privacy Rights. You have the following rights relating to your Protected Health Information and may:

- Obtain a current paper copy of this Notice.
- Inspect or obtain a copy of your records. Your request to obtain a copy of your medical records must be in writing. You may be charged a fee for the cost of copying, mailing or other supplies. We are allowed to deny this request under certain circumstances. In some situations, you have the right to have the denial of your request reviewed by a licensed healthcare professional identified by the Samaritan Health Clinic who was not involved in the original denial decision. We will comply with the outcome of this review.
- Request that we amend your record, if you feel the information is incomplete or incorrect. We are allowed to deny this request in certain circumstances and may ask you to put these requests in writing and provide a reason that supports your request.
- Request in writing a restriction on certain uses and disclosures of your information. We are not required to agree to these restrictions in all circumstances.
- Obtain a record of certain disclosures of your Protected Health Information.
- Make a reasonable request to have confidential communications of your Protected Health Information sent to you by alternative means or at alternative locations.
- We will obtain your written permissions for uses and disclosures of your Protected Health Information that are not covered by the Notice or permitted by law. Except to the extent that the use or disclosure has already occurred, you may cancel this permission. This request to cancel must be put in writing.
- Submit any written requests to inspect, copy or amend your records to the Medical Records Department.

Our Responsibilities. We are required to protect the privacy of your Protected Health Information, abide by the terms of the Notice, make the Notice available to you and to notify you if we are unable to agree to a requested restriction or an alternative means of communicating.

Examples of Uses and Disclosures

We will use your Protected Health Information for treatment. Certain information obtained by a nurse, doctor, or other healthcare worker will be put into your record and used to plan and manage your treatment. We may provide reports or other information to your doctor or other authorized persons who are involved in your care.

We will use your Protected Health Information for payment. A bill may be sent to you and/or your insurance company with information about your diagnosis, procedures and supplies used.

We will use your Protected Health Information for regular healthcare operations. The Medical Staff and other healthcare workers may use your Protected Health Information to check on the care you received, how you responded to it, and for other business purposes related to operating the clinic.

Business Associates: We may share some of your Protected Health Information with outside people of companies who provide services for us, such as typing physician reports.

Notification: We may use or disclose your Protected Health Information to notify a family member or other person involved in your care, your location and general condition unless you tell us not do so.

Communication with Family: We may share your Protected Health Information with a family member, a close personal friend, or a person you identify, if we determine they are involved in your care or in payment for your care, unless you tell us not to do so.

Research: Your Protected Health Information may be used for research purposes in certain circumstances with your permission, or after we receive approval from a special review board whose members review and approve the research project.

Coroners, Medical Examiners, Funeral Directors: We may disclose your Protected Health Information to these people, to the extent allowed by law, so that they may carry out their duties.

Organ Donor Organizations: We may share your Protected Health Information with the organ donation agency for the purpose of tissue or organ donation in certain circumstances and as required by law.

Contacts: We may contact you to provide appointment reminders or to tell you about new treatments or services.

Fundraising and Marketing: We may contact you as a part of any fundraising or marketing effort.

Food and Drug Administration (FDA): We may share your Protected Health Information with certain government agencies like the FDA so they can recall drugs or equipment.

Workers Compensation: We may disclose your Protected Health Information for workers' compensation claims.

Public Health: We may give your Public Health Information to public health agencies who are charged with preventing or controlling disease, injury or disability and as required by law.

Communicable Disease: We may disclose your Protected Health Information to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition, if authorized by law to do so, such as a disease requiring isolation.

Correctional Institution: If you are an inmate of a correctional institution, we may disclose your Protected Health Information needed for your health or the health and safety of others.

Law Enforcement: We may disclose your Protected Health Information for law enforcement purposes as required by law.

As Required by Law: We must disclose your Protected Health Information when required by federal, state or local law.

Health Oversight: We must disclose your Protected Health Information to a health oversight agency for activities authorized by law, such as investigations and inspections. Oversight agencies are those that oversee the healthcare system, government benefit programs, such as Medicaid, and other government regulatory programs.

Abuse or Neglect: We must disclose your Protected Health Information to government authorities that are authorized by law to receive reports of suspected abuse or neglect.

Legal Proceedings: We may disclose your Protected Health Information in the course of any judicial or administrative proceeding or in response to a court order, subpoena, discovery request or other lawful process.

Required Uses and Disclosures: We must make disclosures when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the HIPAA Privacy Regulations.

To Avoid Harm: We may use and disclose information about you when necessary to prevent a serious threat to your health or safety of the health or safety of the public or another person.

For Specific Government Functions: In certain situations, we may disclose Protected Health Information of military personnel and veterans. We may disclose your Protected Health Information for national security activities as required by law.