ZUFALL HEALTH COMMUNITY HEALTH CENTERS

Dental Health History

Confidential

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

DENTAL HISTORY

Reason for Today's Visit: _____ Date of Last Dental Care: _____

Date of Last Dental X-ray: _____

Check ☒ if you have or have had problems with any of the following:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Clicking or popping jaw
- ☐ Sores or growths in mouth
- ☐ Grinding Teeth
- ☐ Loose Teeth or broken filling
- ☐ Periodontal Treatments
- ☐ Food collection between teeth
- ☐ Sensitivity to heat (food or liquid)
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sensitivity to cold (food or liquid)

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

MEDICAL HISTORY

Physician's Name: _____ Date of Last Visit: _____

Have you had any serious illnesses or operations? ☐ No ☐ Yes If yes, describe: _____

Have you ever had a blood transfusion? ☐ No ☐ Yes If yes, give approximate dates: _____

Have you ever taken any group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand name phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine): ☐ No ☐ Yes

(Women) Are you pregnant? ☐ No ☐ Yes Nursing? ☐ No ☐ Yes Taking birth control pills? ☐ No ☐ Yes

Check ☒ if you have or have had problems with any of the following:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatment
- ☐ Cough, Persistent
- ☐ Cough up blood
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Frequent Infections
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Problems
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankle
- ☐ Thyroid Problem
- ☐ Tobacco Habit (smoking or chew)
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATION

List Medications you are currently taking: _____

_____

_____

Pharmacy Name: _____

Phone #: _____

ALLERGIES

- ☐ Aspirin
- ☐ Penicillin
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Barbiturates (Sleep pills)
- ☐ Sulfa
- ☐ Latex: _____
- ☐ Other: _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my child and/or I ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient

INFORMED CONSENT – GENERAL DENTISTRY

1. Request and Authorization. I hereby request and authorize Zufall Health Center and/or such other persons as he/she may appoint, to perform or assist in the performance of dental treatment for one or more of the following conditions:
Dental Decay, Gingivitis, Periodontitis, (Gums Problems), Dental or Gingival Abscess, Mouth Sores or Lesions, Malocclusion, Irreversible or Acute Pulpitis, (Disease of the Nerve of the Tooth), Trauma. Any other oral conditions and diseases.

2. Changes in Treatment Plan. During the course of the treatment, procedures may need to be added, expanded or changed because conditions are found that were not identified during examination and first were observed during the course of treatment. The most common include the need for root canal therapy and more extensive restorative procedures, like crowns, bridges or implants. Permission is hereby given to perform any additional or expanded dental services that the Dentist determines are necessary. Further, at the Dentist's discretion, I may be referred to a specialist for further treatment, the cost of which is my responsibility.

3. The Procedure(s). The procedure(s) necessary to treat the condition(s) will be explained to me, and will be listed on the treatment plan. Alternative treatment plans will also be explained to my satisfaction, and I am encouraged to ask questions until I fully understand the treatment proposed.

4. Risks and benefits. The risks and benefits of the preferred treatment plan and alternative treatment plan will be explained to me. In addition, the doctor will explain the risks of not having any dental procedures performed.

5. Drugs, Medications and Anesthesia. Drugs, medications or anesthesia can cause allergic and other reactions. Examples include, but are not limited to, swelling, redness, itching, vomiting, diarrhea, numbness or tingling of the lip, gum or tongue (which in rare cases may be permanent) and also in rare cases, anaphylactic shock. Since they also may cause drowsiness and impair coordination or awareness, a motor vehicle or hazardous device should not be operated before full recovery is achieved. I have informed the dentist of all drugs and medications I am taking or have taken within the last 30 days as well as those that have been prescribed within the last 6 months but not taken, and all allergies and sensitivities of which I am aware. I have been informed and understand that failure to take drugs or medications as prescribed by Dentist may result in continued or aggravated infection and pain and potential resistance to effective treatment. In addition, antibiotics can reduce the effectiveness of birth control pills.

6. Fillings. The most common conditions encountered with fillings are pain, sensitivity to temperature or pressure, fractures of teeth or roots, nerve damage, damage to other teeth, occlusal (bite) discrepancies, temporomandibular joint problems and occasional allergic reactions to filling materials.

7. Crowns, Onlays/Inlays, Bridges, Veneers and Bonding. Sometimes it is difficult or impossible to exactly match the color of artificial teeth or restorative materials with natural teeth. Although assistance will be provided by the Dentist, it is my responsibility to make changes, if any, (including, for example, shape, size, fit and color) before permanent cementation. After a temporary crown has been placed, it is essential to have the new crown cemented as soon as it is ready because the temporary crown is not intended to function as a permanent restoration. Failing to replace the temporary crown could lead to decay, gum disease, infections, problems with the bite and even loss of the tooth. Further, if there is a prolonged delay in placing the permanent crown, it may no longer properly fit.

I am responsible for understanding my treatment and will ask questions and discuss treatment alternatives, risks, outcomes and costs with the Dentist before making a decision. I understand that dentistry is not an exact science and that there are no guaranteed results. Unless otherwise provided by law, I understand that I am responsible for payment of all fees not paid in full by any insurance or applicable coverage.

Patient's Signature	Date	Witness (staff member)	Date
Parent or Legal Guardian (if under 18)	Date		

ZUFALL HEALTH COMMUNITY HEALTH CENTERS

PATIENT REGISTRATION
(Registro de Paciente)

Today's *Date*
(Fecha de hoy): _____

Legal Name (Nombre Legal):	**Preferred Name (Nombre Preferido):**		
Pronouns (Pronombres): ☐She/her/hers (ella) ☐He/him/his (él) ☐They/them/theirs (elle) ☐Other (otro):			
Address (Dirección):	**City (Ciudad):**	**State (Estado):**	**Zip (Codigo postal):**
Phone numbers (Números de Teléf.) **Home (Casa):** **Cell (Celular):**	**Birth Date (Month/Day/Year):** **Fecha de Nacimiento (Mes/Día/Año):**		
Sex at birth (Sexo al nacer): ☐Male (Hombre) ☐Female (Mujer)	**Country of Birth (País de nacimiento):**	**Date of Arrival to USA (Fecha que llegó a EEUU):**	
Marital Status (Estado civil): ☐Single (Soltero) ☐Separated (Separado) ☐Married (Casado) ☐Divorced (Divorciado) ☐Widowed (Viudo) ☐Living together (Viviendo juntos)			
Responsible Party (Persona responsable): ☐Self (Yo mismo) ☐Parent/Guardian (Padre/ Guardián):			
Emergency Contact Name (Nombre del contacto de emergencia): **Phone # (Teléfono):**	**Relationship to patient (Relación con el paciente):**		
Email Address (Correo electronico):	**Preferred language (Idioma preferido):**	**Need translation? (¿Necesita un traductor?)** ☐Yes (Sí) ☐No	

Race *Check ALL that apply (Raza *Marque TODAS las que correspondan):
Definitions of race available upon request (Descripciones de cada raza están disponibles a su solicitud)

☐Asian Indian
☐Chinese
☐Filipino
☐Japanese
☐Korean
☐Vietnamese
☐Other Asian
☐Native Hawaiian (Nativo de Hawái)
☐Other Pacific Islander (De otras islas del Pacífico)
☐Guamanian or Chamorro
☐Samoan
☐Black/African American (Negro/Afroamericano)
☐American Indian/Alaska Native (Indio Americano/Nativo de Alaska)
☐White (Blanco)
☐Decline to specify (Negar contestar)

Ethnicity *Check ALL that apply (Etnicidad *Marque TODAS las que correspondan):

☐Mexican, Mexican American, Chicano/a
☐Puerto Rican
☐Cuban
☐Another Hispanic, Latino/a or Spanish origin (Otra etnicidad hispana/latina)
☐Not Hispanic, Latino/a, or Spanish origin
☐Decline to specify (Negar contestar)

Sexual orientation (Orientación sexual):

☐Straight/heterosexual (Heterosexual)
☐Lesbian/gay/homosexual (Lesbiana/gay/homosexual)
☐Bisexual (Bisexual)
☐Other, sexual orientation not listed (Otra orientación sexual no mencionada)
☐Do not know (No lo sé)
☐Choose not to disclose (Negar contestar)
☐Something else, please describe (Otra orientación sexual, por favor descríbala):

Gender identity (Identidad de género):

☐Male (Hombre)
☐Female (Mujer)
☐Gender non-conforming (Género no binario/no binarie)
☐Other, gender identity not listed (Otra identidad de género no mencionada)
☐Male-to-female transgender (Hombre a mujer - transgénero)
☐Female-to-male transgender (Mujer a hombre - transgénero)
☐Choose not to disclose (Negar contestar)
☐Something else, please describe (Otra orientación sexual, por favor descríbala):

Pharmacy Name (Nombre de su farmacia): **Address (Dirección):**	**Pharmacy Phone # (Teléf. de su farmacia):**

Please continue form on Page 2 (Continúe con el formulario en la página 2) ➔

Employer (Empleador):	Occupation (Ocupación):
Is patient/parent/guardian employed? (¿Está empleado el paciente/padre/guardián?)	☐No ☐Yes/Sí, $_____ Income/benefits from any source (Ingresos/beneficios de cualquier fuente) ☐(Weekly/Semanal) ☐(Biweekly/Quincenal) ☐(Monthly/Mensual) ☐(Yearly/Anual)
Spouse Employed? (¿Está empleado su esposo/a?)	☐No ☐Yes/Sí, $_____ Income/benefits from any source (Ingresos/beneficios de cualquier fuente) ☐(Weekly/Semanal) ☐(Biweekly/Quincenal) ☐(Monthly/Mensual) ☐(Yearly/Anual)
Total Family Income (Ingreso Total Familiar): $_____ ☐N/A ☐(Weekly/Semanal) ☐(Monthly/Mensual) ☐(Yearly/Anual)	**Family Size (Tamaño de su Familia):** _____Adults (Adultos) _____Children (Niños)

I certify that the above information is true and accurate to the best of my knowledge. (Certifico que la infomación anterior es verdadera y correcta según mi entendimiento.)

_____ _____ _____ _____

Signature of Patient (Parent or Guardian)
Firma del paciente (Padre o guardián)

Date (Fecha)

Signature of minor 13 or over
(Firma de un paciente entre 13 a 18 años de edad)

Date (Fecha)

TO BE COMPLETED BY ZUFALL HEALTH REPRESENTATIVE
(Este lado será completado por un representante del centro de salud)

Patient Status:
☐Veteran ☐Public Housing
☐Homeless ☐Farm Worker

Health Insurance:
☐None (uninsured) ☐Commercial
☐Medicare ☐Other:
☐Medicaid _____

Proof of Address:
☐Utility Bill ☐Letter of Support
☐Mortgage ☐Other:
☐Copy of Lease _____

Proof of ID:
☐Birth Certificate ☐Voter Registration Card
☐NJ Driver License ☐Employee ID Card
☐Passport ☐Welfare Card
☐Alien Registry Card ☐Other: _____

Proof of Income: (Check all that apply)
☐Paycheck ☐Attestation (Proof of Income Form)
☐Disability Benefit ☐Unemployment Benefit
☐Statement from Employer ☐Income Tax Return
☐Child Support ☐Social Security
☐Alimony ☐Other: _____

2023 Federal Poverty Level Guidelines

	Federal Slide & NJDHSS	Federal Slide & NJDHSS	Federal Slide & NJDHSS	Federal Slide & NJDHSS	NJDHSS eligible only	NOT eligible for Federal or NJDHSS slide
	A	B	C	D	E	
Family Size*	**up to 100%**	**101% to 150%**	**151% to 175%**	**176% to 200%**	**201 to 250%**	Full charge or Prompt Pay Incentive
1	$0 to 14,580	14,581 to 21,870	21,871 to 25,515	25,516 to 29,160	29,161 to 36,450	
2	$0 to 19,720	19,721 to 29,580	29,581 to 34,510	34,511 to 39,440	39,441 to 49,300	
3	$0 to 24,860	24,861 to 37,290	37,291 to 43,505	43,506 to 49,720	49,721 to 62,150	
4	$0 to 30,000	30,001 to 45,000	45,001 to 52,500	52,5001 to 60,000	60,001 to 75,000	
5	$0 to 35,140	35,141 to 52,710	52,711 to 61,495	61,496 to 70,280	70,281 to 87,850	
6	$0 to 40,280	42,281 to 60,420	60,421 to 70,490	70,491 to 80,560	80,561 to 100,700	
7	$0 to 45,420	45,421 to 68,130	68,131 to 79,485	79,846 to 90,840	90,841 to 113,550	
8	$0 to 50,560	50,561 to 75,840	75,841 to 88,480	88,481 to 101,120	101,121 to 126,400	

***For families/households with more than 8 persons, add $5,140 for each additional person.**

☐NO INCOME; Patient and/or Family Living/Staying with: ☐Family ☐Friend ☐Agency _____ ☐Other
Statement of support must be on file. *Staff enters into structured info section.

_____ _____

Signature of Zufall Health Representative

Date

ZUFALL HEALTH COMMUNITY HEALTH CENTERS

AUTHORIZATION AND INFORMED CONSENT

CONSENT FOR TREATMENT

I understand that by signing this agreement, I indicate my wish to receive health services from Zufall Health Center as determined by the provider(s). I understand that these services may be provided by, or with the assistance of, Medical Doctors, Podiatrists, Dentists, Advance Practice Nurses, Physician Assistants, Licensed Clinical Social Workers, Registered Nurses, Licensed Practical Nurses, and Medical/Dental Assistants. I do hereby consent to such treatment by the clinical staff as may be indicated to be the appropriate standard of care for my illness, injury or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence. I understand that if the provider determines that the recommended treatment cannot be provided by Zufall Health, I will receive the appropriate referral. I understand that no guarantees or assurances have been made to me concerning the results of the proposed care. Regarding reproductive health, I understand services are provided on a voluntary basis and that receipt of family planning services is not a prerequisite to receive any other services offered by Zufall. All services will be provided in a confidential manner.

PATIENT'S RIGHTS AND RESPONSIBILITIES & PRIVACY PRACTICES ACKNOWLEDGEMENT

The Patient's Bill of Rights and Responsibilities & the Notice of Privacy Practices was made available to me for review and a copy will be provided upon request. I understand Zufall Health may contact me by phone, email, or text message regarding coordination of my health care or other Zufall-sponsored activities. If I choose to opt-out of any of these methods of communication, it is my responsibility to notify a Zufall staff member.

RELEASE OF INFORMATION TO OTHER PROVIDERS OF SERVICE

I give my permission to Zufall Health Center to release necessary information concerning my illness and/or treatment to hospitals, physicians or medical agencies/institution, accrediting bodies or individuals, who provide me with health or social services and insurances or other payment agencies. I also give permission to my physician, hospitals and other agencies or individuals to release to Zufall Health Center any portion of my medical records or copies thereof that the health center requests.

CONSENT TO RETRIEVE PREVIOUS PRESCRIPTIONS

I give consent for Zufall Health Center to electronically retrieve any prescriptions that I have had filled by providers other than Zufall Health Center for the purpose of continuity of care and keeping all my medical records in my medical home. This will enable the provider to check for drug-to-drug interactions as well as having a complete and accurate medical record to optimize my medical care.

CERTIFICATON OF INFORMATION

I certify the information provided is true and accurate to the best of my knowledge. I acknowledge that my signature below is my consent for medical care, release of information, and retrieval of prescriptions as described above. A copy of this agreement shall be considered as effective and valid as the original.

_____ _____

Signature of patient age 13 and older Date

(For minors this consent only applies to reproductive and substance abuse services. Minor patients will be counseled about the importance of discussing health care concerns with a parent or other trusted adult.)

*The patient is: _____a minor _____ unable to sign. The above explanations have been made to, and consent has been given by, the patient's legal guardian, power of attorney, or closest available relative who is currently responsible for minor.

_____

Signature of parent/guardian or representative Relationship to patient Date

**(If patient is minor or unable to sign)*

ZUFALL HEALTH COMMUNITY HEALTH CENTERS

Consent to Share Medical Information

Zufall Health Center at times may need to contact you about test results, appointments, referrals or billing/insurance information. By filling out the information below, we will be better able to serve you. In an effort to protect your privacy and follow federal guidelines, we have developed a policy on leaving medical care messages. Unless we have written permission to do so:

1. We will not leave messages with anyone except the patient or legal guardian.
2. We will not leave detailed messages on voice mail or answering machines.

Please read below and carefully consider who, if anyone, you want to have access to your medical information.

I, _____ give my permission for **Zufall Health Center** to leave phone messages regarding my medical care information. I fully understand that this consent will remain valid until revoked in writing by me.

Patient name: _____
Date of Birth: _____

May we leave a phone message to inform you that test results are available and to contact our office for those results?

Home Number: _____ □ Yes □ No
Work Number: _____ □ Yes □ No
Cell Number: _____ □ Yes □ No

Who else may we share your test results with on your behalf?
Spouse/Partner: □ Yes □ No - If "Yes," name: _____
Son/Daughter: □ Yes □ No - If "Yes," name: _____
Other □ Yes □ No - If "Yes," name: _____

Patient Signature: _____ Date: _____

www.zufallhealth.org

ZUFALL HEALTH COMMUNITY HEALTH CENTERS

Thank you providing the following information in order for us to better serve you. All information will be kept confidential.

Sexual Orientation	**Gender Identity**
☐ Lesbian or Gay ☐ Straight (not lesbian or gay) ☐ Bisexual ☐ Something else ☐ Don't know ☐ Choose not to disclose	☐ Male ☐ Female ☐ Transgender Male (Female-to-Male) ☐ Transgender Female (Male-to-Female) ☐ Other ☐ Choose not to disclose

	YES	NO
Agricultural workers (and their family members)		
1. Have you or anyone living with you, such as a spouse or relative, worked in agriculture (on a farm, in a greenhouse or with livestock) in the U.S.A. in the past two years? (This does not include landscaping at private homes.)	☐	☐
2. Have you or any member of your household EVER worked in agriculture and stopped working in it because of age or disability?	☐	☐
3. In the past year have you travelled away from your home and stayed in temporary housing in order to work in agriculture?	☐	☐
Residents of Public Housing	**YES**	**NO**
1. Are you receiving, or have you received, a check from the government to help you pay your rent at any time in the past year?	☐	☐
2. Do you get assistance or a voucher, (like Section 8) to help you pay your rent?	☐	☐
3. Do you live in a subsidized housing building?	☐	☐
Housing Status	**YES**	**NO**
1. Do you live in a shelter or transitional housing now or did you within the past year?	☐	☐
2. Do you live with others, or rent a room in a house, to share expenses in what you consider a temporary basis until you can afford to move into a more permanent or more stable situation? (This does not include students sharing housing during the school year, or friends or relatives living together because they prefer that living arrangement.)	☐	☐
3. Are you staying at someone else's house, or moving among friends temporarily because you had to leave your home or apartment? (Sometimes called couch surfing)	☐	☐
4. Were you without a place to stay within the past year?	☐	☐
5. Have you received an eviction notice in the past year or were you at any time at risk of homelessness?	☐	☐
Veterans		
1. Have you served in the U.S. military or armed forces for any period of time?	☐	☐

Do you have an advanced directive? ☐ Yes ☐ No

How did you hear about Zufall Health?

☐Self ☐Friend ☐Family ☐Other Zufall Patient ☐Community Agency ☐Internet ☐Hospital ☐Zufall Staff

☐Insurance ☐Event (Please specify):_____ ☐Other:_____

_____

Signature of Patient **Date**