WACO FAMILY MEDICINE

School Dental Clinic Consent Form

Please fill out and return all attached forms.

Good dental health helps kids stay healthy, learn better, and do well in school. Licensed dental professionals from Waco Family Medicine will come to your child's school to give preventative dental care.

This care may include inspecting their teeth, x-rays, cleaning, fluoride application, and dental sealants to prevent decay in permanent molars.

Services are for students who turn in all signed forms and haven't had a dental check-up in the last 6 months.

If your child has dental insurance, we will bill it. If there's a co-pay, we'll contact you.

Parents don't need to be present.

Every child seen will get a dental report card and a goodie bag.

If more care is needed, we'll refer your child to one of our dental clinics.

If your child does not have insurance, we offer a sliding fee scale based on household income. Check this box to learn more: ☐

I give consent for my child to receive preventative dental services from Waco Family Medicine's School-Based Dental Team. ☐ Yes ☐ No

This consent form is valid for 365 days following signature.

Child's Name _____

Child's Date of Birth _____

Parent/Guardian Name _____

Parent/Guardian Signature _____

For questions, please contact Misty at 254-313-6110 | wacofamilymedicine.org

WACO FAMILY MEDICINE

Annual Registration

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Name _____

Address _____ Apt# _____

City _____ State _____ Zip _____

Birthdate _____ SSN _____ Patient / Guardian E-Mail _____ @_____

Home Phone _____ Cell Phone _____ Employer Work Phone _____

Preferred Communication: ☐ Phone ☐ Email (MyChart) ☐ US Mail **Preferred Pharmacy:** ☐ Waco Family Medicine ☐ Other _____

PREFERRED LANGUAGE
- ☐ English
- ☐ Spanish
- ☐ Signing / ASL
- ☐ Other

MARITAL STATUS
- ☐ Single
- ☐ Married
- ☐ Widowed
- ☐ Divorce

SEX AT BIRTH
- ☐ Male
- ☐ Female

HISPANIC OR LATINO/A ETHNICITY
- ☐ Not Hispanic, Latino/a, or Spanish Origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, Another Hispanic, Latino/a or Spanish Origin

RACE (MARK ALL THAT APPLY)
- ☐ White
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Asian Indian
- ☐ Black/African American
- ☐ Other Asian
- ☐ American Indian/ Alaskan Native
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Native Hawaiian
- ☐ Other Pacific Islander

SEXUAL ORIENTATION
- ☐ Straight
- ☐ Lesbian
- ☐ Gay
- ☐ Bisexual
- ☐ Something Else
- ☐ Do Not Know
- ☐ Choose Not to Disclose

GENDER IDENTITY
- ☐ Male
- ☐ Female
- ☐ Choose Not to Disclose

HOMELESS STATUS
- ☐ Not Homeless
- ☐ Doubled Up (Living With Others)
- ☐ In A Homeless Shelter
- ☐ Transitional Housing
- ☐ On the Street
- ☐ Permanent Supportive Housing (MHMR/Family Abuse Center)

IN PUBLIC HOUSING
- ☐ Yes
- ☐ No

VETERAN STATUS
- ☐ Active Duty
- ☐ Discharged (Veteran)
- ☐ National Guard
- ☐ Reserves
- ☐ None

FARM WORKER STATUS
- ☐ Migratory Farm Worker
- ☐ Seasonal Farm Worker
- ☐ Not a Farm Worker

HOUSEHOLD INFORMATION

How many people are in your household including yourself? _____ What is your monthly household income? _____

☐ I have no income. ($0) ☐ My Monthly Income is $_____ ☐ My Yearly Income is $ _____

PARENT / GUARDIAN / GUARANTOR INFORMATION

Financially Responsible Person | Patients under the age of 18 MUST have a Guarantor

Name _____ Birthdate _____ SSN _____

Address _____ Apt# _____ City _____ State _____ Zip _____

Employer _____ Home Phone _____ Cell Phone _____ Work Phone _____

PRIMARY **MEDICAL** INSURANCE

Insurance Name _____

Member ID _____ Group # _____

Is the policy holder the patient? ☐ Yes ☐ No

Policy Holder Name _____ Male Female

Birthdate _____ SSN _____ Relationship to Patient _____

Address _____ City _____ State ____ Zip _____

PRIMARY **DENTAL** INSURANCE

Insurance Name _____

Member ID _____ Group # _____

Is the policy holder the patient? ☐ Yes ☐ No

Policy Holder Name _____ Male Female

Birthdate _____ SSN _____ Relationship to Patient _____

Address _____ City _____ State ____ Zip _____

WACO FAMILY MEDICINE

GENERAL CONSENT TO TREAT

I hereby consent to any and all treatment that my Waco Family Medicine (hereinafter "WFM") clinician and I agree is necessary for me or for the patient(s) I am guardian for.

I understand and acknowledge that WFM is a teaching center, and my care, and/or the care of patients(s) I am guardian for, at WFM may be provided by a clinician, including but not limited to medical students and/or resident physicians and/or resident dentists, in a clinical training program. I further understand and acknowledge that teaching services such as direct observation by other physicians or medical students and case discussions of care activities involving me or my dependents are allowed for teaching purposes unless specifically denied by me. I understand and acknowledge that certain clinical visits may be delivered by telehealth (video or telephone) services, during which I will not be physically in the same room as my clinician. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties. If it is determined that the telecommunications or information technology is not adequate, my telehealth visit may be discontinued or converted into an in-person visit.

I further understand that as part of its health care services, WFM personnel and my clinician create and maintain a record of care and services provided. I understand that such information may be used and/or disclosed in the management and delivery of care and services provided by WFM, as described in the Notice of Privacy Practices. I understand and acknowledge that WFM participates in an electronic health record exchange program, and that if I seek treatment from other healthcare facilities or providers participating in this exchange program, my health information, or that of the patient(s) I am guardian for, may be shared between WFM and those other facilities or providers. I understand and acknowledge that as part of receiving my healthcare at Waco Family Medicine, WFM's clinicians and other personnel may electronically request and/or provide health records for me and/or patient(s) I am guardian for, to those participating facilities or providers. These records include, but are not limited to prescription medication history, as well as information related to mental health treatment, alcohol and/or drug abuse diagnosis, prognosis and treatment, and/or HIV (AIDS) testing/results and/or treatment. I further understand that any such information from any source whatsoever may become part of the requesting party's health records about me and/or the patient(s) I am guardian for.

By providing my mobile phone number, I consent to text messages regarding upcoming appointments and other notifications related to my healthcare and services provided by Waco Family Medicine. I understand that there may be text or data charges from my mobile carrier.

NOTICE OF PRIVACY PRACTICES I hereby understand that I have the right to request a copy of Waco Family Medicine's Notice of Privacy Practices.

LIMITED ENGLISH PROFICIENCY Waco Family Medicine proudly offers language assistance to its patients free of charge. WFM also strives to make reasonable accommodations for disabled patients.

PHOTOGRAPHY AND VIDEO I understand WFM personnel and/or my clinician may request to take photographic and/or video images for the purpose of identification and documentation of my medical care. I also understand that such images may be used for teaching purposes. I understand that I have the right to refuse to have such photographic and/or video images taken.

STATEMENT OF FINANCIAL RESPONSIBILITY I hereby acknowledge I am the person primarily responsible for payment of all charges for services rendered by Waco Family Medicine, regardless of any insurance coverage I might have, including Medicare or Medicaid, and that such payment is due on demand. I understand that I may be charged for multiple services provided on the same day. (For example, WFM offers integrated behavioral health services; this means that many patients are offered the opportunity to see a counselor during the same visit that they see a medical clinician. This may result in additional charges. You have the right to decline these same-day counseling services.) I understand that any payments I make that exceed the charges for an individual visit or service will be applied to any outstanding balance on my patient account and that such overpayments may not be refunded to me unless my account balance is $0. I further understand that in addition to such service charges, I will be liable for any court costs, attorney's fees, collection expense, or interest that may be incurred should such actions be required to obtain payment for services rendered by Waco Family Medicine. I certify that the patient and financial information given at the time of services rendered is accurate and complete.

ASSIGNMENT OF INSURANCE BENEFITS In consideration of service rendered, I hereby irrevocably assign and transfer to WFM, all rights, title and interest in benefits payable for services rendered by Waco Family Medicine. I hereby authorize and instruct the insurance company and/or Financial Program to pay directly to Waco Family Medicine all benefits due under the terms of my policy or policies. I understand that my insurance policy/financial program, or their health-insuring agent(s), determine the medical necessity of services/items I request and receive. I also understand that I am responsible for payment of services or items I request and receive if these services/items are determined by my insurance policy/financial program not to be reasonable and medically necessary for my care.

OUTSIDE DIAGNOSTIC CHARGES Laboratory testing for specimens as well as imaging services (x-rays/CT/ultrasounds) performed at Waco Family Medicine may be sent to an independent lab or radiologist and will be billed to me directly from that independent facility. There is also a lab handling fee for obtaining lab specimen(s) which is billed through Waco Family Medicine. Upon receiving a statement, I understand that I am to contact that laboratory or radiology company to arrange payment or exchange insurance information. I understand that these diagnostic charges are my financial responsibility.

PARENT / GUARDIAN / GUARANTOR SIGNATURE

I have read and understand this document.

Patient Signature _____ Date _____

Parent/Guardian Signature* _____ Relationship to Patient _____

Printed Name _____ ***Proof of Legal Guardianship May Be Required**

OFFICE USE ONLY

Processed By _____

WACO FAMILY MEDICINE

Dental Medical History

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Name _____

Date _____ Gender _____ Family Status _____ Birthdate _____ SSN _____

Home Phone _____ Cell Phone _____ Communication Preference Cell Text

Address _____ Apt# _____

City _____ State _____ Zip _____

HEALTH INFORMATION

Date of Last Dental Visit _____ Reason for this visit _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE CHECK THOSE THAT APPLY:

- AIDS
- Allergies _____
- Anemia
- Arthritis
- Artificial Joints
- Asthma
- Blood Disease
- Cancer
- Diabetes
- Dizziness
- Epilepsy
- Excessive Bleeding
- Fainting
- Glaucoma
- Growths
- Hay Fever
- Head Injuries
- Heart Disease
- Heart Murmur
- Hepatitis
- High Blood Pressure
- Jaundice
- Kidney Disease
- Liver Disease
- Mental Disorders
- Nervous Disorders
- Pacemaker
- Pregnancy
  - Due date _____
- Radiation Treatment
- Respiratory Problems
- Rheumatic Fever
- Rheumatism
- Sinus Problems
- Stomach Problems
- Stroke
- Tuberculosis
- Tumors
- Ulcers
- Venereal Disease
- Codeine Allergy
- Penicillin Allergy
- OTHER
  - _____
  - _____
  - _____
  - _____
  - _____

Have you taken or currently taking Bisphosphonate? Yes No

If yes, please explain _____

Please list any drugs or medications you are presently taking _____

Have you ever had any complications following dental treatment? Yes No

If yes, please explain _____

Have you been admitted to a hospital or needed emergency care during the past two years? Yes No

If yes, please explain _____

Are you now under the care of a physician? Yes No

If yes, please explain _____

Name of Physician _____ Phone _____

Do you have any health problems that need further clarification? Yes No

If yes, please explain _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of Patient, Parent/Guardian _____ Date _____

OFFICE USE ONLY Reviewed By _____ Date _____

WACO FAMILY MEDICINE

Patient and Center Rights and Responsibilities

Welcome to Waco Family Medicine

Our goal is to provide quality health care to people in this community. As a patient, you have rights and responsibilities. The Center also has rights and responsibilities. We want you to understand these rights and responsibilities so you can help us provide better health care for you. Please read and sign this statement and ask us any questions you might have.

I have read, understand, and accept Waco Family Medicine Patient and Center Rights and Responsibilities. A copy of this policy is available to me upon my request.

These rights and responsibilities address:

- Human Rights
- Payment for Services
- Privacy
- Health Care
- Center Medical Home Responsibilities
- Patient Responsibilities
- Complaints
- Termination
- Appeals

Patient Name _____

Date of Birth _____ MMR# _____

Signature _____ Date _____

Name _____

Print Your Name

If signing for a minor, _____

Print Minor's Name

WACO FAMILY MEDICINE

General Consent

DEPARTMENT OF DENTAL SERVICES

A Service of Waco Family Medicine
1600 Providence Drive, Waco, Texas 76707
(254) 313-4900 Fax (254) 313-4999

I, _____, consent to be a patient of the dentists of Waco Family Medicine and agree to a radiographic and clinical examination.

I also understand and consent to the following:

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery,endodontics (root canals), fixed and removable prosthodontics (crowns, bridges,and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, oral pathology, pediatric dentistry, and radiography.

2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4. My treatment plan may change at any time. This may include additional procedures and treatment that were not initially planned.

5. I understand that my treatment may require referral to a specialist. I understand that I am financially responsible for any treatment by a specialist.

6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

7. I understand that my treatment may be completed by a dental student or resident under the direct oversight of the faculty dentists of the Center.

Patient or Guardian Name _____ Date _____

Witness Name _____ Date _____

WACO FAMILY MEDICINE

Access Information

AUTHORIZATION

This form tells your clinic team who they can talk to about your health.

I ________________________________, (printed adult patient name & date of birth) hereby authorize Waco Family Medicine staff to disclose any and all of my health information to the following individual(s) until further notice is given.

OR

For ____________________________, (printed minor patient name & date of birth)

Please list individuals Waco Family Medicine can contact in the event of an emergency or release your health information to: (NOTE | You must designate at least one Emergency Contact)

Name ____________________________ Relationship _________________ Contact Information ______________________

Emergency Contact ☐ Yes ☐ No Release Other Health Information ☐ Yes ☐ No Consent to Treatment ☐ Yes ☐ No

Name ____________________________ Relationship _________________ Contact Information ______________________

Emergency Contact ☐ Yes ☐ No Release Other Health Information ☐ Yes ☐ No Consent to Treatment ☐ Yes ☐ No

Name ____________________________ Relationship _________________ Contact Information ______________________

Emergency Contact ☐ Yes ☐ No Release Other Health Information ☐ Yes ☐ No Consent to Treatment ☐ Yes ☐ No

Name ____________________________ Relationship _________________ Contact Information ______________________

Emergency Contact ☐ Yes ☐ No Release Other Health Information ☐ Yes ☐ No Consent to Treatment ☐ Yes ☐ No

I consent to allow my school nurse permission to discuss the clinical treatment of my child with Waco Family Medicine even if I am not present or able to participate in the appointment. This consent is valid for 365 days.

☐ Yes ☐ No School Name ______________________________________

Patient or Parent/Guardian Signature ____ Date __________

Appropriate identification has been presented and verified.

Name of Staff Member/Department ____

Clinic Name ____ Date __________________