

INSURANCE COVERAGE: Must have all insurance cards front and back.		
Check all that apply: None <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private Insurance <input type="checkbox"/> Blue Chip <input type="checkbox"/> Indian Health Center <input type="checkbox"/> VA <input type="checkbox"/>		
Primary Insurance Company/Address	ID Number	Group Number
	SS #	
Name of Insured	Relationship to Patient: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____	
Secondary Insurance Company/Address	ID Number	Group Number
	SS #	
Name of Insured	Relationship to Patient: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____	

**PARTNERSHIP HEALTH CENTER
323 WEST ALDER STREET
MISSOULA, MT 59802**

AUTHORIZATION AND ASSIGNMENT

The information given on this form is true to the best of my knowledge.

Treatment/Payment Agreement for Partnership Health Center (PHC).

I request the above to provide me and/or my family with medical care. I accept responsibility to pay for this care according to the fees established. Furthermore, I authorize assignment of benefits for medical/dental service to be paid to PHC. Also, I authorize PHC to bill my insurance and release information to the insurance company if requested.

Signed _____ **Date** _____

FOR PHC USE: STAFF INITIALS	DATE:	SLIDING SCALE: A B C D E NONE
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FINANCIAL STATUS WORKSHEET

VERIFY ALL SOURCES OF GROSS INCOME (PROOF OF INCOME IS NECESSARY TO QUALIFY FOR SLIDING FEE)

Family Income	Yes	No
Wages		
Self Employment		
Unemployment		
Workers Compensation		
Retirement/Pension		
Social Security		
Disability		
Food Stamps		
Child Support		
Alimony		
Other (please indicate)		

TOTAL GROSS INCOME: _____

Complete Medical/Dental History

Name: _____ Date of Birth: _____
Address: _____
Phone: _____ Social Security Number: _____

Please answer each question for the patient listed. If you answer YES to any question, please write a complete description.

1. Are you allergic or have you reacted adversely to:

____ Local Anesthetics (Novocain, Lidocaine) ____ Penicillin, or other antibiotics ____ Sulfa Drugs ____ Aspirin
____ Barbiturates, Sedatives, Sleeping Pills ____ Iodine ____ Codeine ____ Latex

Other _____

2. Check any of the following you have had, or have been exposed to:

____ Heart Trouble ____ Heart Murmur ____ Hepatitis ____ High Blood Pressure ____ Asthma
____ Cough ____ Tuberculosis ____ Jaundice ____ Chronic Swollen Gums ____ Epilepsy
____ Diabetes ____ Sinus Trouble ____ Stroke ____ Rheumatic Fever ____ HIV
____ Blood Disorders ____ Artificial Joints

3. How often do you brush your teeth? _____ How often do you floss? _____

4. Do you use a soft, medium, or hard toothbrush? _____

5. What brand of toothpaste do you use? _____

6. When was the last time you went to the dentist, and why? _____

7. Do you smoke? ____ If yes, how many packs a day? ____ Do you use smokeless tobacco? ____

8. Have you been a patient in the hospital in the past two years? If so, why? _____

9. Are you under the care of a physician now, or in the last two years? If so, why? _____

10. Have you taken any kind of medicine or drugs during the past two years? _____ If so, what was the name/type? _____

11. Have you had any other serious illnesses? _____

Describe: _____

12. Do you bruise easily, or have you ever had a large amount of bleeding from a tooth extraction or a cut on your skin? _____

13. Are you PREGNANT? If yes, how many months? _____

14. Do (or did) either or both of your parents wear dentures? _____

15. Do you grind or clench your teeth together at night? _____

16. Have you ever felt dizzy or fainted after a dental treatment? _____

17. Have you ever had any injuries to your face, teeth or jaws? _____

18. Have you ever had an unfavorable reaction to dental treatment? _____

****MAY WE TAKE DENTAL RADIOGRAPHS (X-RAYS)? _____**

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE

Patient Signature (Or Parent/Guardian if Patient is Under 16) Date