summit community
CARE CLINIC

REGISTRATION FORM

DOB: Marital Status: Single / Married	Email:
First Name: Middle Initial:	Are you a veteran: Yes / No
Last Name:	Are you pregnant: Yes / No Due Date:
Gender: M / F SSN: _____ - _____ - _____	Do you have health insurance: Yes / No — Medicare□ Private Ins. □ Medicaid □
PO Box: City: Zip:	Does your insurance cover family planning: Yes / No
Physical Address:	Name of Employer:
City, State, Zip:	Second job:
Home # : Cell # :	Are you self employed: Yes / No
As a courtesy we give our patients reminder calls prior to their appointments. Can we leave a message for you? **Yes / No** If yes, what phone number do you prefer we call _____	Other sources of income:
Parent or Guardian Name, if patient is under 18: _____	

Family Gross Income $_____ Week / Every 2 weeks / Month / Year
Number of people living in the same household supported by this income
(Including yourself) _____

Please CIRCLE:

RACE *(CIRCLE AT LEAST ONE)*	**PRIMARY LANGUAGE** *(CIRCLE AT LEAST ONE)*	**ETHNICITY** *(CIRCLE ONE)*
BLACK OR AFRICAN AMERICAN	AMERICAN SIGN LANGUAGE	HISPANIC ORIGIN
AMERICAN INDIAN OR ALASKA NATIVE	ENGLISH	NOT HISPANIC ORIGIN
ASIAN	FRENCH	NOT PROVIDED
WHITE	POLISH	
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	RUSSIAN	
NOT PROVIDED	SPANISH	
	OTHER	

Please tell us who to contact in case of an emergency (parent or guardian if patient is under 18):

An emergency would be severe bleeding, unconsciousness, accident or a condition requiring ambulance transport or hospitalization. Family planning services DO NOT require parental permission; however, in an emergency situation, if you are under 18 years of age, we will notify a parent or guardian.

Does the person listed below know that you are receiving services here? YES ____ NO ____

EMERGENCY CONTACT NAME _____
RELATIONSHIP _____PHONE # _____

I certify that the above information is true, accurate, and complete to the best of my knowledge, (incorrect or false information will result in termination of services). I permit Summit Community Care Clinic representatives to contact any necessary person or agency to verify this information. If further information is needed, I must furnish it within 30 days.

I agree to notify Summit Community Care Clinic promptly of any change in household members, address, phone, income, insurance or other essential information. I understand that I must show my card at time of service.

I understand that I am responsible for any charges for service and I agree to pay for services at the time of service. I hereby consent to all treatment which the medical staff of Summit Community Care Clinic determines to be necessary

If you are completing this form for another person, what is your relationship to that person?
Your Name: _____ ***Relationship:*** _____

X **X**

Applicant Signature **Date**

FOR STAFF USE ONLY

SYSC TITLE X FULL FEE

ANNUAL INCOME $ _____

FEE CODE _____ HH _____

DENTAL TEMP PRENATAL CC CICP

ANNUAL INCOME $ _____

FEE CODE _____ HH _____

EXPIRATION _____ /_____ /_____

Limited English Proficiency? YES NO

INITIALS _____

DATE _____ /_____ /_____

Summit Community Care Clinic Dental Health History Form

Name: _____ Birth Date: _____Today's Date_____

Dental Information – Please circle Y or N.

- Do you gums bleed when you brush or floss? **Y or N**
- Do you have sensitive teeth? **Y or N**.
- Do you feel that your mouth is often dry? **Y or N**
- Have you had any periodontal (gum) treatments? **Y or N**
- Have you had orthodontic treatment (braces)? **Y or N**
- Have you had any problems associated with past dental treatment? **Y or N**
- Do you have any clicking, popping, or discomfort in the jaw? **Y or N**
- Do you grind your teeth? **Y or N**
- Do you have sores or ulcers in your mouth? **Y or N**
- Have you ever had a serious injury to your head or mouth? **Y or N**

What is the date of your last dental exam? _____

Are you currently experiencing dental pain or discomfort? Please describe briefly. _____

What is the reason for your dental visit today? _____

Medical Information – Please circle Y or N.

- Are you under the care of a physician? **Y or N**
- Has there been a change in your general health with the past year? If so, what condition is being treated? _____ **Y or N**
- Date of last physical exam: _____
- Have you had a serious illness, operation or been hospitalized in the past 5 years? _____ **Y or N**
- Are you taking any prescription or over the counter medicines? **Y or N**
- **Please list all medications you are taking**. _____
  _____
  _____

- Women Only:

Are you Pregnant? **Y or N** Number of Weeks: _____ Nursing? **Y or N**

Allergies

Are you allergic to, or have you had an allergic reaction to:

Local anesthetics	**Y or N**	Codeine or other narcotics	**Y or N**	Sulfa Drugs	**Y or N**
Aspirin	**Y or N**	Metals	**Y or N**	Hay Fever/seasonal	**Y or N**
Penicillin or other antibiotics	**Y or N**	Latex (rubber)	**Y or N**	Food	**Y or N**
Barbiturates or sedatives	**Y or N**	Iodine	**Y or N**	Other: _____	

Medical Conditions/Diseases

Have you had or do you have any of the following conditions?

Cardiovascular disease	**Y or N**	Autoimmune disease	**Y or N**	Thyroid disease	**Y or N**
Angina	**Y or N**	Rheumatoid arthritis	**Y or N**	Stroke	**Y or N**
Congestive heart failure	**Y or N**	Systemic lupus erythematosus	**Y or N**	Glaucoma	**Y or N**
Damaged heart valves	**Y or N**	Asthma	**Y or N**	Hepatitis, or liver disease	**Y or N**
Heart attack	**Y or N**	Bronchitis	**Y or N**	Epilepsy	**Y or N**
Heart murmur	**Y or N**	Emphesema	**Y or N**	Fainting spells or seizures	**Y or N**
Low blood pressure	**Y or N**	Sinus Trouble	**Y or N**	Neurological disorders	**Y or N**
High blood pressure	**Y or N**	Tuberculosis	**Y or N**	Sleep disorder	**Y or N**
Mitral valve prolapse	**Y or N**	Cancer/Chemotherapy/		Mental health disorders	**Y or N**
Pacemaker	**Y or N**	Radiation Treatment	**Y or N**	Recurrent infections	**Y or N**
Rheumatic fever	**Y or N**	Chest pain upon exertion	**Y or N**	Kidney problems	**Y or N**
Rheumatic heart disease	**Y or N**	Chronic pain	**Y or N**	Night sweats	**Y or N**
Abnormal bleeding	**Y or N**	Diabetes: Type I or Type II	**Y or N**	Osteoporosis	**Y or N**
Anemia	**Y or N**	Eating disorder	**Y or N**	Persistent swollen glands in neck	**Y or N**
Blood transfusion	**Y or N**	Malnutrition	**Y or N**	Severe headaches/ migraines	**Y or N**
Hemophilia	**Y or N**	Gastrointestinal disease	**Y or N**	Severe or rapid weight loss	**Y or N**
AIDS or HIV infection	**Y or N**	G.E. Reflux/heartburn	**Y or N**	Sexually transmitted disease	**Y or N**
Arthritis	**Y or N**	Stomach ulcers	**Y or N**	Excessive urination	**Y or N**

Joint Replacement

Have you had an orthopedic total joint replacement? (hip, knee, elbow, finger) **Y or N**

Date: _____ If yes, have you had any complications? _____

Bisphosphonate Medication

• Are you taking or scheduled to begin taking either of the following medications: alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? **Y or N**

• Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? **Y or N**

Date treatment began: _____

Premedication

Have you had or do you have any of the following conditions?

Artificial (prosthetic) heart valve	**Y or N**
Previous infective endocarditis	**Y or N**
Damaged valves in transplanted heart	**Y or N**
Congenital heart disease (CHD)	
Unrepaired, cyanotic CHD	**Y or N**
Repaired (completely) in last 6 months	**Y or N**
Repaired CHD with residual defects	**Y or N**

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? **Y or N**

Do you drink alcohol or use drugs? **Y or N**

If yes,

• Have you had more than 3 (women) or 4 (men) drinks in one day in the past 3 months? **Y or N**
• Do you drink more than 7 (women) or 14 (men) drinks per week? **Y or N**
• In the past 12 months, have you ever used drugs other than those required for medical reasons? **Y or N**
• Have you ever used IV drugs? **Y or N**
• Have you smoked cigarettes or used other tobacco products in the past 3 months? **Y or N**

Over the **past 2 weeks**, have you had any of the following problems **more than half the time**?

• Feeling down, depressed, or hopeless? **Y or N**
• Having little interest or pleasure in doing things? **Y or N**

Dr. Signature_____