Date: ___/___/____

Langley Health Services

Patient Information- Page 1

Legal Name: (Last) (First) (Middle Initial)	**Preferred Name:**
Legal Sex (sex assigned at birth): ☐ Female ☐ Male	**Date of Birth:** Month/Day/Year _____/_____/_____
Social Security Number: _ _ _ - _ _ - _ _ _ _	**Email Address:**
Home Phone: (_ _ _) _ _ _ - _ _ _ _ Ok to leave voicemail? ☐ Yes ☐ No	**Cell Phone:** (_ _ _) _ _ _ - _ _ _ _ Ok to leave voicemail? ☐ Yes ☐ No
Work Phone: (_ _ _) _ _ _ - _ _ _ _ Ok to leave voicemail? ☐ Yes ☐ No	**Best Number to Use:** ☐ Home ☐ Cell ☐ Work
Street Address: (Street) (City) (State) (Zip Code)	
Mailing Address: (Street) (City) (State) (Zip Code)	

Employment Status: ☐ Employed Full-time ☐ Employed Part-time ☐ Student full-time ☐ Student part-time ☐ Retired ☐ Unemployed ☐ Other
Employer Name:
Employer Address:
Employer Phone Number:

The information below is for demographic purposes only and will not affect your care.

1. What is your annual income? ☐ $1-$27,000 ☐ $27,001 - $33,000 ☐ $33,001 - $40,000 ☐ $40,001+ ☐ No income 1a. How many people (including you) does your income support? _____	**2. Which describes your housing situation (choose one):** ☐ Own/Rent ☐ Live with friend/doubling up ☐ Street/Car ☐ Shelter ☐ Transitional ☐ Other: _____	**3. Racial Group(s)** *check all that apply* ☐ African American/Black ☐ Asian ☐ Caucasian/White ☐ Native American/Alaskan Native ☐ Pacific Islander ☐ Other: _____	**4. Ethnicity** ☐ Hispanic/Latino(a) ☐ Not Hispanic/Latino(a) **5. Country of Birth** ☐ USA ☐ Other: _____
6. Preferred Language (choose one): ☐ English ☐ Español ☐ Other: _____ **7. Veteran Status** ☐ Veteran ☐ Not a Veteran	**8. Marital Status** ☐ Married ☐ Partnered ☐ Single ☐ Divorced ☐ Other:_____	**9. Do you think of yourself as:** ☐ Lesbian, gay, or homosexual ☐ Straight or heterosexual ☐ Bisexual ☐ Something else ☐ Don't know **10. What is your gender?** ☐ Female ☐ Male ☐ Genderqueer or not exclusively male or female	**11. Migrant/Seasonal Farm Workers (in the past 2 years):** Have you, or head of household, worked in agricultural labor? ☐ Yes ☐ No Did you, or head of household, move from this area to another county or state in search of agricultural work? ☐ Yes ☐ No Has your family earned more than half their income from seasonal agriculture? ☐ Yes ☐ No

Emergency Contact Name:	**Emergency Contact Number:**

TURN OVER TO PAGE 2

Patient Information- Page 2

Responsible Party Information

(Person financially responsible for patient's account)

If same as above, go to insurance information section

Legal Name: (Last) (First) (Middle Initial)			**Date of Birth:** Month/Day/Year _____/_____/_____
Home Phone: (_ _ _) _ _ _ - _ _ _ _	**Cell Phone:** (_ _ _) _ _ _ - _ _ _ _	**Work Phone:** (_ _ _) _ _ _ - _ _ _ _	**Social Security Number:** __ __ __ - __ __ - __ __ __ __
Street Address: (Street)	(City)	(State)	(Zip Code)
Mailing Address: (Street)	(City)	(State)	(Zip Code)

Insurance Information

Primary Insurance Company

Insurance Company Name:			
Address: (Street)	(City)	(State)	(Zip Code)
ID #:	**Group #:**	**Employer Name:**	
Name of Insured:	**Date of Birth of Insured:** Month/Day/Year _____/_____/_____	**Social Security Number of Insured:** __ __ __ - __ __ - __ __ __ __	
Mailing Address of Insured: (Street)	(City)	(State)	(Zip Code)
Home Phone of Insured: (_ _ _) _ _ _ - _ _ _ _	**Cell Phone of Insured:** (_ _ _) _ _ _ - _ _ _ _	**Work Phone of Insured:** (_ _ _) _ _ _ - _ _ _ _	
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other			

Secondary Insurance Company

Insurance Company Name:			
Address: (Street)	(City)	(State)	(Zip Code)
ID #:	**Group #:**	**Employer Name:**	
Name of Insured:	**Date of Birth of Insured:** Month/Day/Year _____/_____/_____	**Social Security Number of Insured:** __ __ __ - __ __ - __ __ __ __	
Mailing Address of Insured: (Street)	(City)	(State)	(Zip Code)
Home Phone of Insured: (_ _ _) _ _ _ - _ _ _ _	**Cell Phone of Insured:** (_ _ _) _ _ _ - _ _ _ _	**Work Phone of Insured:** (_ _ _) _ _ _ - _ _ _ _	
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other			

Patient Consents and Acknowledgements

PATIENT NAME: _____ DATE OF BIRTH: _____

	INITIAL
I. Consent for Treatment I hereby give consent and authorize examination and treatment at Project Health, Inc. d/b/a Langley Health Services (LHS) for myself, the patient, by the personnel at LHS. The need for the examination and treatment, and the possibility of undesirable side effects, will be explained by the employees of LHS. I understand there is no guarantee or assurance, as to the results which may be obtained, but normal prudent care will be exercised by employees or LHS concerning my diagnosis and treatment.	
II. Consent for Treatment of a Minor ***only complete if patient is under 18 years of age*** I, as the parent or legal guardian of the patient, _____, do hereby give my consent and authorize treatment. Furthermore, I grant permission for the following individuals to authorize Medical Treatment in my absence: 1. _____ **Relationship to patient:**_____ 2. _____ **Relationship to patient:**_____ 3. _____ **Relationship to patient:**_____	
III. Notice of Privacy Practices I acknowledge that I have received the practice's Notice of Privacy which describes the ways in which the practice may use and disclose my healthcare information for its treatment and payment/healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Compliance Officer if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy.	
IV. Release of Information • Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions or for any other purpose related to benefit payment. • If I am covered by Medicaid or Medicare, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, drug and alcohol treatment and discharge summary. • Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases such as HIV and AIDS. I hereby permit the practice and the physicians or other health professionals involved in my care to release healthcare information for purposes of treatment, payment, and/or healthcare operations.	
V. Medical Home: I choose to participate in the Patient-Centered Medical Home (*information about PCMH is posted throughout the clinic)*.	
VI. Patient Rights, Responsibilities and Information and Patient Centered Medical Home These documents are posted in the lobby. I acknowledge that I have received a copy.	
VII. Consent for Use and Disclosure of Protected Health Information (PHI) Project Health, Inc. d/b/a Langley Health Services (LHS) is committed to ensuring the privacy and confidentiality of your medical information. To assist us in protecting your privacy, please complete the following information:	

(Check Yes or No)	Yes	No
May we leave a clinical message if no answer?		
May we leave a billing concern message if no answer?		
May we send an appointment reminder using text messaging? *If yes, what is your cell phone carrier?* _____		
May we send you an email regarding reminders and clinical notes?		

May we leave information with someone other than you regarding your medical care (medication changes, laboratory results, appointments, etc? ☐ Yes (If yes, please list the name(s) in the space(s) below) ☐ No

Name	Relationship	Phone Number

**You have the right to revoke whom we talk with about your health care at anytime. Please complete a new consent.

VIII. Notice Regarding Appointments

Your appointment time is time set aside for YOU to meet with your provider. The amount of time set aside was based on your needs.

- You are expected to arrive 15 minutes before your appointment. Every effort will be made to see you on time. If you are more than 10 minutes late, your provider may not be able to see you. You may then be seen in the Walk-In Clinic, or by another provider, depending on the urgency of your need and available time.
- If you cannot keep your appointment, it is important to let us know 24-48 hours in advance. We can then use the time to serve someone else. This makes good use of your provider's time and makes it easier for everyone to get an appointment when they need it.
- If you miss your appointment, your prescription may not be refilled until you come in for your next appointment.

IX. Notice of Policy Regarding Advanced Directives (for patients over 18 years of age)

Advanced Directives are legal statements that indicate the type of medical treatment wanted or not wanted in the event an individual is unable to make decisions as well as who is authorized to make them. Advance directives are made and witnessed prior to serious injury.

In accordance with federal and state law, this serves as notification that we will set aside your advance directive in the event you experience a life threatening event while at one of the Langley Health Services locations and you will be transferred to a higher level of care.

By signing below, you agree and understand this as notification. Please indicate below whether or not you have an advanced directive or if you would like to receive information on advance directives.

☐ I have an advanced directive.
☐ I do not have an advanced directive.
☐ I would like to receive information on advanced directives.

X. Residents and Students

I understand that Project Health, Inc. d/b/a Langley Health Services supports the education of medical professionals and maintains Residents and Students that may assist in relation to care.

XI. Assignment of Medicare Benefit *(ONLY FOR PATIENTS COVERED BY MEDICARE)*

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment or authorized benefits be made on my behalf. I assign the benefits payable for physician services or authorize such physician or organization to submit a claim to Medicare and request payment of medical insurance benefits to the party who accepts assignment. I permit a copy of this authorization to be used in place of the original, as long as I receive services at LHS. I understand that I am responsible for my co-insurance amount on Medicare coverable services. I further understand that the Part B deductible does not apply to FQHC services; however, should I receive services that are non-covered under FQHC, I will be responsible for the part B deductible. I have completed a copy of the Medicare Secondary Payor (MSP) Questionnaire.

_____ Signature of Patient or Parent/Guardian

_____ Signature of Witness

_____ Printed name of Patient or Parent/Guardian

_____ Printed Name of Witness

_____ Date

_____ Date

Informed Consent for Dental Procedures

Patient Name: _____ **Patient Date of Birth: _____**

All patients complete 1 through 4 below

PROCEDURE	INITIALS TO CONSENT
1. EXAMINATIONS AND X-RAYS I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. I understand a detailed treatment plan will be given. I hereby give consent and authorize examination and treatment at Project Health, Inc. d/b/a Langley Health Services (LHS) by the personnel at LHS. The need for the examination and treatment, and the possibility of undesirable side effects, will be explained by the employees of LHS. I understand there is no guarantee or assurance, as to the results which may be obtained, but normal prudent care will be exercised by employees or LHS concerning my diagnosis and treatment. Informed Consent for Dental Procedures will be obtained.	
2. DRUGS AND MEDICATION I have been informed and understand that antibiotics and analgesics and other medications can cause allergic reactions resulting in redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I have informed the Dentist of all known allergies and all medications I am currently taking.	
3. CHANGES IN TREATMENT PLAN I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on teeth that were undetectable during examination. Any change in the plan will be explained immediately and a new consent will be signed if necessary. The most common change in treatment plan being the discovery of the need for root canal therapy during or following restorative procedures.	
4. TEMPOROMANDIBULAR JOINT DYSFUNCTION I understand that popping, clicking, locking and pain can intensify or develop in the joints (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise I will be referred to a specialist for treatment, the cost of which is my responsibility.	

INFORMED CONSENT FOR BITEWINGS

I, _____ **(patient's name)** understand that my insurance does not cover the bitewing x-rays that are necessary for proper diagnosis during the New Patient/Recall Examination.

I understand the fee is $49.00; this amount is my responsibility and due at the New Patient/ Recall Examination.

Insurances that does not cover bitewings are
Staywell/ Liberty
Prestige/Argus
Sunshine/ Envolve

Patient's Signature: _____ DOB: _____ Today's Date: _____

Consent for Dental Treatment by Student

The Dental Department at Langley Health Services is participating in a program for the training of dental students, hygiene students, and dental assisting students. This program provides quality care for the patients, and gives the students a variety of clinical experiences unique to a community health center setting. Students are well along in their training and some have already completed all clinical requirements for graduation.

The licensed staff at Langley Health Services will act as clinical instructors and will be supervising the students and evaluating the treatment they provide in order to assure the best possible outcomes. Accepting treatment by students increases the participating patient's access to appointments allowing for more timely completion of needed treatment. Please feel free to ask any questions about the program at any time.

I, _____, understand that a student may be providing
(Print Patient/Parent/Guardian's Name)
dental care to me or my child, _____. I understand that
(Child's Name)
the services provided by the student will be under the supervision of a licensed dentist who is at the clinic while the student is delivering dental care. I hereby give my consent

for a dental student to perform treatment. I agree that I have had the chance to ask any questions I may have about this agreement.

Patient's Name(Print):_____ Date:_____

Patient/Parent/Guardian's Signature:_____

LHS Witness:_____

Today's Date:_____

Langley Health Services Medical History

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

Physician's Name:_____ **Physician's Phone:**_____ **Date of Last Exam:**_____

Are you under medical treatment now? _____yes _____no
***If yes, what for?** _____

Have you had any serious illnesses or been hospitalized in the past five years? _____yes _____no
***If yes, what for?**_____

Do you have or have you had any of the following? (Please check yes or no)

Heart Disease	_____yes	_____no	Cough	_____yes	_____no
Rheumatic Fever	_____yes	_____no	Arthritis	_____yes	_____no
High Blood Pressure	_____yes	_____no	Stroke	_____yes	_____no
Low Blood Pressure	_____yes	_____no	Glaucoma	_____yes	_____no
Ulcer/Reflux	_____yes	_____no	Syphilis	_____yes	_____no
Tuberculosis	_____yes	_____no	Gonorrhea	_____yes	_____no
Lung Disease	_____yes	_____no	Herpes	_____yes	_____no
Diabetes	_____yes	_____no	Mitral Valve Prolapse	_____yes	_____no
Emphysema	_____yes	_____no	Nervous Disorder	_____yes	_____no
Anemia	_____yes	_____no	Sickle Cell Anemia	_____yes	_____no
Congenital Heart Defects	_____yes	_____no	Artificial Heart Valve	_____yes	_____no
Communicable Diseases	_____yes	_____no	Liver Disease	_____yes	_____no
Hemophilia	_____yes	_____no	Leukemia	_____yes	_____no
Psychiatric/Mental Disorders	_____yes	_____no	Respiratory Problem	_____yes	_____no
Addictions	_____yes	_____no	Cardiac Pacemaker	_____yes	_____no
AIDS, ARC, HIV	_____yes	_____no	Sexually Transmitted Disease	_____yes	_____no
Artificial Joint	_____yes	_____no	Cancer	_____yes	_____no
Radiation Therapy	_____yes	_____no	Swollen Ankles	_____yes	_____no
Prolonged Bleeding	_____yes	_____no	Thyroid Problem	_____yes	_____no
Fainting/Seizures	_____yes	_____no	Chest Pains	_____yes	_____no
Excessive Urination	_____yes	_____no	Easily Winded	_____yes	_____no
Heart Murmur	_____yes	_____no	Epilepsy/Convulsion	_____yes	_____no
Hepatitis/Jaundice	_____yes	_____no	Kidney Disease	_____yes	_____no
Asthma	_____yes	_____no	Joint Replacement	_____yes	_____no
Implant	_____yes	_____no	Heart Attack	_____yes	_____no
Hay Fever/Sinus	_____yes	_____no	Other (List Below)	_____yes	_____no

Do you have any medical conditions that are not listed above? If so, please list: _____

_____

Tobacco Use?	_____yes	_____no
Controlled substances?	_____yes	_____no
Ever taken Phen-fen/Redux?	_____yes	_____no

Women only:

Pregnant and/or think you might be?	_____yes	_____no
Are you nursing?	_____yes	_____no
Currently taking oral contraceptives?	_____yes	_____no

Patient's Name:_____ Date of Birth:_____

Are you allergic to, or have you had any reactions to the following?

Penicillin	_____yes _____no	Symptoms:	_____
Other Antibiotics	_____yes _____no	Symptoms:	_____
Local Anesthetics *Lidocaine, Novocaine, etc.	_____yes _____no	Symptoms:	_____
Metals *nickel, silver, etc.	_____yes _____no	Symptoms:	_____
Aspirin	_____yes _____no	Symptoms:	_____
Sulfa Drugs	_____yes _____no	Symptoms:	_____
Latex rubber	_____yes _____no	Symptoms:	_____
Sedatives	_____yes _____no	Symptoms:	_____

Do you have any allergies that are not listed here? _____yes _____no

***If yes, please list:** _____

Medications:

Are you taking any medications, including non-prescription medicine? _____yes _____no

*If yes, please list them: **(Please use back for additional space)**

_____ _____ _____

_____ _____ _____

_____ _____ _____

Dental History:

Name of Previous Dentist & Location: _____ **Last Exam Date:** _____

Do you have, or have you had, any of the following?

Sensitive teeth?	_____yes	_____no	Frequent Headaches?	_____yes	_____no
Painful teeth?	_____yes	_____no	Orthodontics(Braces)?	_____yes	_____no
Jaw or Facial pain?	_____yes	_____no	Do you like your smile?	_____yes	_____no
Clenching/Grinding?	_____yes	_____no			

Authorization and Release for Medical History:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

Signature of patient (parent or guardian if minor)

---------- OFFICAL USE ONLY ----------

Doctor's Comments: _____

_____

Updates: Date:_____ Any Changes?_____ Pt's Initials:_____

Date:_____ Any Changes?_____ Pt's Initials:_____