Form 102

East Central Oklahoma Family Health Center, Inc.

109 South Main
Wetumka, OK 74883

1102 West Main
Henryetta, OK 74437

217 South 5th
Henryetta, OK 74437

Patient Information

Name: _____ Birthdate: _____ Age: _____

Sex: M F SSN: - - Home Phone Number: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip _____

Cell Phone: _____ Cell Phone Carrier: _____ Race: _____ Marital Status: S M D

PT Employer: _____ Address: _____

Employer Phone: _____ Position: _____

Spouse's Name: _____ Spouse Employer: _____

Address: _____ Phone _____

PT Employment Status: Employed: Not Employed: Self: Retired: Active Duty: Veteran:

Student Status: Full Time: Part Time: Not a Student:

Race: (circle one) Black/African American American Indian/Alaska Native Native Hawaiian White

Other Pacific Islanders Asian More than One Race

Ethnicity: (circle one) Hispanic/Latino/Spanish Non-Hispanic/Latino Decline to Report

Please indicate the category for your annual household income (for statistical purposes only): (circle one)

$0 - $11,490 $11,491 – $22,980 $22,981 – $45,960 $45,961 – $68,940

$68,941 and Above I choose not to answer

Pharmacy Name: _____

Person Responsible For Bill (If Other Than Patient)

Name _____ **Birthdate** _____ **Parent/Guardian SSN** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Employer _____ **Business Phone** _____ **Position** _____

Form 102

Insurance Coverage

Company Policy Holder Holder's Birthdate Holder's SSN Policy ID # Group # Employer

1. _____

2. _____

Emergency Contact

Nearest Relation (Not Living In Household)

Name _____ Relationship _____

Address _____ Phone _____

Employer: _____ Address: _____

Phone: _____

Second Contact _____ Relationship _____

Address: _____ Phone _____

Employer: _____ Address: _____

Phone _____

Authorizations Treatment Release: I authorize my physician to provide the patient reasonable and proper medical care by today's standards.

Benefits To Physician: I hereby authorize payments to the ECOFHC for medical benefits. I also understand that I am responsible for any of my bill not covered by insurance.

Release of information: I hereby authorize release of information for insurance claim purposes Photostat of the above is valid as the original

I understand all of the above and hereby state that the information is correct to my knowledge. My signature indicates that I have read that a above and grant the request of authorizations.

SIGNED _____ DATE: _____

East Central Oklahoma Family Health Center, Inc.
About Our Notice of Patient Privacy Practices

We are committed to protecting your personal health information in compliance with the law.
The attached Notice of Patient Privacy Practices states:

- Our obligations under the law with respect to your personal health information.
- How we may use and disclose the health information that we keep about you.
- Your rights relating to your personal health information.
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to uses and disclosures not described in this Notice.
- The person to contact for further information about our privacy practices.

We are required by law to give you a copy of this notice and to obtain your written acknowledgement that you have received a copy of this notice.

Patient Acknowledgment of Receipt

I, _____, hereby acknowledge that I have been offered/received a copy of the Notice of Privacy Practices.
Patient Name

EAST CENTRAL OKLAHOMA FAMILY HEALTH CENTER, INC.
Release of Protected Health Information

Please identify the person or persons you authorize your Protected Health Information (oral or recorded information) to be released to by East Central Oklahoma Family Health Center, Inc. This may include your spouse, parents, siblings, children, friends or guardian. Please list below:

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____

East Central Oklahoma Family Health Center, Inc. is required to have your permission to leave messages regarding your Protected Health Information (test results, instructions, appointment reminders, etc.).

Please check the appropriate boxes:

Yes, ECOFHC, Inc. **may** leave a message on my answering machine/voice mail regarding my Protected Health Information.

No, ECOFHC, Inc. **may not** leave a message on my answering machine/voice mail regarding my Protected Health Information.

_____ **Patient Signature**

_____ **Signature of Parent or Patient's Representative (if applicable)**

_____ **Date**

_____ **Description of Legal Authority to Act on Behalf of Patient**

EAST CENTRAL OKLAHOMA FAMILY HEALTH CENTER, INC.

Sliding Fee Discount Application

Name: _____ Date: _____

DOB: _____ # of Household Members: _____

HOUSEHOLD INFORMATION MUST BE COMPLETED FOR ALL HOUSEHOLD MEMBERS

List all members of household and date of birth.

1. Name: _____ DOB: _____
2. Name: _____ DOB: _____
3. Name: _____ DOB: _____
4. Name: _____ DOB: _____
5. Name: _____ DOB: _____

HOUSEHOLD INCOME FOR ALL HOUSEHOLD MEMBERS (Proof of income must be copied and attached)

Employer Name of/Self Employed: _____ Phone # _____

Gross Wages per pay period: $ _____

How often are you paid? *(check one)* [ ] Daily [ ] Weekly [ ] Twice/monthly [ ] Monthly

OTHER INCOME

Please indicate amount and frequency of receipt: $_____ per _____
(amount) *(week, month, etc.)*

Circle all sources of other income which may include:

self-employment	wages	tips	Unemployment Benefits
Social Security SSI	Child Support	Public Assistant (TANF)	Housing Allowance
Military Family	Allotment	Pension Benefits	VA Benefits
Trust Fund Disbursement	Training Stipends	Scholarships	Grants

Food Stamps Any other form of financial support: specify: _____

Form 118 Sliding Fee Discount Application

Additional Important Information:

- The Front Desk Staff/Patient Representative will explain to the applicant the amount of fee reduction after they are qualified to receive the Sliding Fee Scale Discount.
- The application and income verification must be updated at least once per year.
- If any of the information on the application changes, please update with the Front Desk Staff/ Patient Representative. This includes income, persons living in the household, address, phone number, etc. This may change your Sliding Fee Scale Discount.
- Income verification must be submitted with Application.
- I understand that I am responsible for any charges above the allotted discount, including the nominal fee and any procedures, x-rays, or lab tests that do not qualify for sliding fee discount.

You may submit the completed application with all required proof of income to any of our facilities (or mail them to: ECOFHC, PO Box 236, Wetumka, OK 74883).

I understand I do not qualify for a Sliding Fee Discount if my income is above 200% Federal Poverty Levels (FPL).

If the application is missing any of the above income information or is not signed, it will be denied. Incomplete applications will be considered void if all information is not received within 30 days."

I certify that all statements contained herein are true and correct and subject to investigation. I also authorize the release of employment records and other financial information to an agent of ECOFHC for sliding fee determination purposes. If any information is submitted falsely, I understand that my Sliding Fee Discount will be revoked and I will be responsible for the full charges owed.

APPLICANT SIGNATURE: _____ **DATE:** _____

Medical Discount (check one): [ ] 100% [ ] 75% [ ] 50% [ ] 25% [ ] Denied: Pay full charges

Dental Discount (check one): [ ] 100% [ ] 75% [ ] 50% [ ] 25% [ ] Denied: Pay full charges

VALID UNTIL: _____ *STAFF SIGNATURE COMPLETING APPLICATION:* _____

Review Date: _____

Revised 07/2014

Form 402 Dental Health History

Medical History

Do you have a personal physician? **Yes_____** **No _____** **Name: _____**

Phone #: _____ **Date of last visit: _____**

Your current health is: **Good _____** **Fair _____** **Poor _____**

Is your physician treating you for a specific condition? **Yes _____** **No _____**

Please explain, if yes: _____

_____

List all current medications and dosages: _____

_____

_____

***Females only*:**

Are you pregnant? **Yes _____** **No _____** **If yes, week #_____**

Are you nursing? **Yes _____** **No _____**

Are you taking birth control pills? **Yes _____** **No _____**

Please check any condition you currently have or have had in the past.

Cardiovascular:

Heart failure	_____	**Heart disease or attack**	_____	**Angina pectoris (chest Pain)**	_____
High blood pressure	_____	**Low blood pressure**	_____	**Heart Murmer**	_____
Mitral valve prolapsed	_____	**Rheumatic fever**	_____	**Congenital heart defect**	_____
Artificial heart valve	_____	**Arrythmias**	_____	**Heart pacemaker/defibrillator**	_____
Heart transplant	_____	**Heart surgery**	_____	**Prior Phen-fen use**	_____
Stroke	_____	**Aneurysm**	_____	**Other heart problems**	_____

Hematologic:

Blood transfusion	_____	**Anemia**	_____	**Hemophilia**	_____
Leukemia	_____	**Sickle Cell disease**	_____	**Tendency to bleed longer**	_____

Neural and sensory:

Eye pain	_____	**Vision problems**	_____	**Glaucoma or cataracts**	_____
Earaches	_____	**Ringing in ears**	_____	**Hearing loss**	_____
Severe headaches	_____	**Fainting/dizziness**	_____	**Epilepsy**	_____
Nervousness	_____	**Psychiatric treatment**	_____	**Development delay**	_____

Gastrointestinal

Stomach ulcers	_____	**Gastritis**	_____	**Colitis**	_____		
Persistent diarrhea	_____	**Liver disease**	_____	**Yellow jaundice**	_____		
Cirrhosis	_____	**Hepatitis** _____	**Hep A**_____	**Hep B**_____	**Hep C** _____		

Respiratory

Hay fever	_____	**Sinusitis**	_____	**Seasonal allergies**	_____

Form 402 Dental Health History

Medical History

Do you have a personal physician? Yes_____ No _____ **Name:** _____

Phone #: _____ **Date of last visit:** _____

Your current health is: Good _____ Fair _____ Poor _____

Is your physician treating you for a specific condition? Yes _____ No _____

Please explain, if yes: _____

_____

List all current medications and dosages: _____

_____

_____

***Females only*:**

Are you pregnant? Yes _____ No _____ If yes, week #_____

Are you nursing? Yes _____ No _____

Are you taking birth control pills? Yes _____ No _____

Please check any condition you currently have or have had in the past.

Cardiovascular:

Heart failure	_____	Heart disease or attack	_____	Angina pectoris (chest Pain)	_____
High blood pressure	_____	Low blood pressure	_____	Heart Murmer	_____
Mitral valve prolapsed	_____	Rheumatic fever	_____	Congenital heart defect	_____
Artificial heart valve	_____	Arrythmias	_____	Heart pacemaker/defibrillator	_____
Heart transplant	_____	Heart surgery	_____	Prior Phen-fen use	_____
Stroke	_____	Aneurysm	_____	Other heart problems	_____

Hematologic:

Blood transfusion	_____	Anemia	_____	Hemophilia	_____
Leukemia	_____	Sickle Cell disease	_____	Tendency to bleed longer	_____

Neural and sensory:

Eye pain	_____	Vision problems	_____	Glaucoma or cataracts	_____
Earaches	_____	Ringing in ears	_____	Hearing loss	_____
Severe headaches	_____	Fainting/dizziness	_____	Epilepsy	_____
Nervousness	_____	Psychiatric treatment	_____	Development delay	_____

Gastrointestinal

Stomach ulcers	_____	Gastritis	_____	Colitis	_____
Persistent diarrhea	_____	Liver disease	_____	Yellow jaundice	_____
Cirrhosis	_____	Hepatitis _____	Hep A_____	Hep B_____	Hep C _____

Respiratory

Hay fever	_____	Sinusitis	_____	Seasonal allergies	_____

Form 402 Dental Health History

Asthma	_____	**Chronic cough**	_____	**Emphysema**	_____
Tuberculosis (TB)	_____	**Breathing difficulty (COPD)**	____	**Supplemental oxygen**	_____

Endocrine

Diabetes	_____	**Insulin-dependent (IDDM)**	_____	**Non-insulin dependent (NIDDM)**	_____
Thyroid Disease	_____	**Hyper-thyroidism**	_____	**Hypo thyroidism**	_____

Urinary/Sexually Transmitted Diseases

Urinate frequently	_____	**Kidney problems**	_____	**Bladder problems**	_____

Sexually transmitted disease (STD: syphilis, gonorrhea, genital herpes) _____

HIV-Positive	_____	**AIDS (or exposed)**	_____

Dermal/Skeletal

Latex allergy	_____	**Abnormal mole**	_____	**Osteoporosis**	_____
Sore Muscles	_____	**Stiff joints**	_____	**Arthritis**	_____
Artificial joint	_____	**Fever blisters**	_____	**Mouth ulcers (canker sores)**	_____

Other Conditions

Frequent sore throats	_____	**Enlarged lymph node**	_____	**Tumor or cancer**	_____
Radiation treatment	_____	**Chemotherapy**	_____	**Surgical removal of tumor**	_____
Use of tobacco	_____	**Smokeless tobacco**	_____	**Cigarettes/Cigars**	_____
# of packs per day	_____	**# of years tobacco use**	_____	**Alcohol use**	_____
Drug addiction	_____	**Steroid therapy**	_____	**Other conditions**	_____

Drug Allergies

Aspirin	_____	**Codeine**	_____	**Penicillin**	_____	**Erythromycin**	_____
Sulfa	_____	**Tetracycline**	_____	**Latex**	_____	**Dental anesthetic**	_____

Other _____ **No known drug allergies** _____

I understand that the information that I have given today is correct to the best *of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.*

I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____ _____

Patient Signature ***Date***

_____ _____

Reviewed By ***Date***

PATIENT'S DENTAL CONSENT

East Central Oklahoma Family Health Center, Inc.
109 South Main, Wetumka, OK 74883; 217 South 5th, Henryetta, OK 74437

Date: _____ Time: _____

1. 1, _____, (the _____
   Of _____), hereby consent voluntarily to dental care including diagnostic procedures, examination and dental treatment including but not limited to routine work and administration of medication prescribed by the dentist.
2. I consent for treatment by a hygienist or dentist designee as necessary in the dentist judgment.
3. I consent to performance of oral surgery, oral or IV sedation, use of nitrous oxide, etc.
4. I consent to photographs or X-rays necessary for diagnosis, and for educational purposes.
5. I understand only appropriately trained personnel will do these procedures.
6. I understand that this consent form will be valid and remain in effect as long as I use the clinic, or until revoked in writing.
7. I have been notified of ECOFHC's policy not to honor any DNR. A copy will be provided to other facilities as needed.

RELEASE OF INFORMATION:

1. I authorize the clinic to release medical information to third party insurance carriers for the purpose of filing insurance claims related to my medical care.
2. I also authorize payment directly to East Central Oklahoma Family Health Center, Inc. but not to exceed the customary chart for those services.
3. I agree to pay the balance not covered by insurance in the manner agreed upon at the time of my income review.
4. Payment history may also be released.
5. I give consent for information regarding my immunizations to be released to other Health Care Providers, Schools, Day Care, and/or Department of Human Services.
6. The information authorized for release may include records which indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as Hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS); and may include information about drugs, alcohol and sickle cell anemia [63 O.S. 1-502.2 (B)].

This form has been fully explained to me and I understand its contents.

ACKNOWLEDGEMENT OF PRIVACY PRACTICE: A complete description of how your medical information will be used and disclosed by this facility is in our **NOTICE OF PRIVACY PRACTICES**. A copy is included in your welcome packet and is made available to you.

COMMENTS: _____

_____ _____

Signature of Patient or Person Authorized to Consent for Patient ***Signature of Person who Explained the Contents of this Consent***

****

If patient is a minor or is unable to consent, complete the following:

A. Patient is a minor _____ years of age.
   Name of Father _____ Mother
B. Patient is unable to consent because: _____

Revised 03/10

Form 404

EAST CENTRAL OKLAHOMA FAMILY HEALTH CENTER, INC.
EXTRACTION CONSENT

The recommendation that one or more of your teeth be extracted is based upon your symptoms, examination of your mouth, or your choice. A surgical procedure may be required to gain access to those teeth to be extracted. In many cases an incision will be made in the gum tissue and bone may be removed to gain access. We want you to be aware of the commonly known risks and side effects of this procedure.

Due to proximity, teeth adjacent to those to be extracted, may be chipped or damaged during extraction.

Nerves which supply sensation to your mouth, chin, lips, tongue and gum tissue may run near the area of the extraction. After the extraction you may experience some alteration of normal nerve sensation (itching, burning or tingling, for example) for a short or indefinite period of time. In some rare instances you may experience a total lack of sensation for a period of time which could be indefinite.

For teeth in the upper arch, there is a risk that following the extraction, a hole or pathway may be present between the sinus and the oral cavity. This is because the roots of some of the upper teeth end just below the floor of the sinus and sometimes actually go through the sinus floor.

Occasionally, the decision is made to leave a small piece of root in the jaw after an extraction in cases when its removal would require extensive surgery and increase the risk of complications.

Following the procedure, the muscles of your jaw may be stiff and sore. It may also be difficult to open wide for several days. This is usually a temporary condition in which moist heat and analgesics will provide pain relief. Occasionally, the jaw joint (TMJ) may be injured due to extended opening required for the procedure. In addition, bone fractures can occur.

You may experience pain, swelling or bleeding for a time after the extraction. If any of these problems occur, they should only last for a few days. Should any of these problems be more severe or last longer than anticipated, call our office immediately.

You may also experience a painful but harmless condition commonly referred to as a dry socket. This occurs when the protective blood clot in the socket where the tooth was removed, is dislodged. This exposes and irritates the delicate nerve endings in the socket. This is usually caused by failing to closely follow the post-operative instructions given. Although the condition is temporary and not harmful, it is painful. It can be treated by a in-house procedure. Medicine is placed in the socket which will soothe and protect it while alleviating the pain.

If you have any further questions, be sure to consult your dental professional. By signing below, you acknowledge that you have read this document, understand the information presented, had all of your questions answered satisfactorily, understand that you may see a specialist and are choosing to see the treating dentist and consent to the indicated treatment.

_____	_____
Patient Name (please print)	Procedure
_____	_____
Signature of patient, legal guardian or authorized representative	Date
_____	_____
Witness to signature	Date