# SWLA Center for Health Services

## Patient Registration Form

***Check one:*** ☐ Lake Charles ☐ Lafayette ☐ Crowley ☐ Oberlin ☐ Sowela

**DATE: _____/_____/_____** **INTAKE SIGNATURE: _____**

| **Patient's First Name:** | **Middle:** | **Last Name:** | **Social Security Number:** _____/_____/_____ | **Sex at birth:** |
|---|---|---|---|---|

| Date of Birth: _____/ _____ /_____ | Physical Address City / State / Zip: | Mailing Address City/State/Zip: |
|---|---|---|

| Home/Cell Number: ( ) _____-_____ | Work Number: ( ) _____-_____ | Email Address: |
|---|---|---|

Primary Insurance: _____ ☐ Medicaid ☐ Medicare ☐ Other

**Pharmacy:** ☐ **SWLA Pharmacy** ☐ **Other** _____ **Phone** _____

| ***PRIMARY LANGUAGE SPOKEN*** | ***ETHNICITY*** | ***RACE*** |
|---|---|---|
| ***Check One:*** ☐ English ☐ Spanish Other _____ | ***Check One:*** ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Refuse to report | ***Check all that apply:*** ☐ Asian ☐ White ☐ Black/African American ☐ Native Hawaiian ☐ American Indian / Native Alaskan ☐ Pacific Islander ☐ Other ☐ Refuse to report |

| ***SEXUAL ORIENTATION*** | ***GENDER IDENTITY*** |
|---|---|
| ***Check One:*** ☐ Straight/Heterosexual ☐ Lesbian / Gay ☐ Bisexual ☐ Something else ☐ Don't Know ☐ Choose not to disclose | ***Check One:*** ☐ Male ☐ Female ☐ Transgender Female ☐ Transgender Male ☐ Other ☐ Choose not to disclose |

***EMPLOYMENT INFORMATION***

| Employer: | Address: | City / State / Zip: |
|---|---|---|

***EMERGENCY CONTACT***

| Name of Emergency Contact: | Relationship to Patient: | Home Number: | Cell Number: |
|---|---|---|---|

| ***Marital Status:*** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed | Phone Number: ( ) _____ |
|---|---|

As a Federal Program we are required to capture financial information. This information is used for ***statistical data only.***

**Are you interested in the Sliding Fee Discount Program?** ☐ **YES** ☐ **NO** **Do you live in Public Housing?** ☐ **YES** ☐ **NO**

***ADDITIONAL INFORMATION - CHECK ALL THAT APPLY***

☐ Homeless—Street, Shelter, Doubling or Transitional

☐ Permanent Supportive ☐ Migratory Agricultural worker ☐ Seasonal Agricultural Worker ☐ Veteran ☐ Other

I hereby certify that all answers and statements on this document and all the information provided is true and accurate. I understand that any misrepresentation or omission of facts. I hereby authorize SWLACHC permission to obtain insurance verification and information from parties outside of SWLA Center for Health Services.

Signature _____ Date _____

***PLEASE FILL THIS FORM OUT COMPLETELY***

**Revised 03/22**

# SWLA Center for Health Services

## Medical and Dental History Form

Patient Name: _____ DOB_____/_____/_____

Address: _____

What brings you in today? _____

Are you having pain or discomfort at this time? ☐ Yes ☐ No

If yes, please explain? _____

What was the date of your last dental visit and/or professional dental cleaning? _____

Have you been under the care of a medical doctor in the past two years? ☐ Yes ☐ No
Have you taken any medications or drugs in the past two years? ☐ Yes ☐ No

Medical Doctor's Name: _____

Address: _____

Telephone: _____

If you have any heart conditions, please list the name of your cardiologist, phone number, and the date of your last visit.
_____

Are you or have you ever been allergic to any medication? ☐ Yes ☐ No

If yes, please list medications: _____

When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? ☐ Yes ☐ No

Do you ever wake up from sleep and feel short of breath? ☐ Yes ☐ No

Have you lost or gained more than 10 pounds in the past year? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No

Has your medical doctor ever said you have cancer or a tumor? ☐ Yes ☐ No

If yes, please list date of diagnosis and location of cancer or tumor. _____
Did you receive radiation to your head/neck area or chemotherapy treatment? ☐ Yes ☐ No

Do you use tobacco products (smoke or chew tobacco) and/or drink any alcoholic beverages? ☐ Yes ☐ No

If yes, how often and how much? _____

**Please list ALL surgeries and hospitalizations throughout life and the date of occurrence in the chart below.**

| SURGERY/HOSPITALIZATION | DATE |
|---|---|
| 1. | |
| 2. | |
| 3. | |

Do you have or have you had any disease, or condition not listed on this form? ☐Yes ☐No

If yes, please list: _____

**Indicate which of the following you have had, or have at present. Circle "Yes" or "No" for each item.**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Heart Disease or Attack | Yes ☐ | No ☐ | Stroke | Yes ☐ | No ☐ | Psychiatric Treatment (depression/anxiety) | Yes ☐ | No ☐ |
| Heart Failure | Yes ☐ | No ☐ | Kidney Trouble | Yes ☐ | No ☐ | Drug Addiction | Yes ☐ | No ☐ |
| Angina Pectoris (Chest Pains) | Yes ☐ | No ☐ | High Cholesterol | Yes ☐ | No ☐ | Nervousness | Yes ☐ | No ☐ |
| Congenital Heart Disease | Yes ☐ | No ☐ | Venereal Disease | Yes ☐ | No ☐ | AIDS | Yes ☐ | No ☐ |
| Heart Murmur | Yes ☐ | No ☐ | Arthritis | Yes ☐ | No ☐ | HIV Positive | Yes ☐ | No ☐ |
| Artificial Heart Valve | Yes ☐ | No ☐ | Rheumatism | Yes ☐ | No ☐ | Blood Transfusion | Yes ☐ | No ☐ |
| High Blood Pressure | Yes ☐ | No ☐ | Cortisone Medication | Yes ☐ | No ☐ | Cold sores/Fever blisters/ Herpes | Yes ☐ | No ☐ |
| Mitral Valve Prolapse | Yes ☐ | No ☐ | Cosmetic Surgery | Yes ☐ | No ☐ | Fainting or Dizzy Spells | Yes ☐ | No ☐ |
| Heart Pacemaker | Yes ☐ | No ☐ | Anemia | Yes ☐ | No ☐ | Yellow Jaundice | Yes ☐ | No ☐ |
| Heart Surgery | Yes ☐ | No ☐ | Thyroid Problems | Yes ☐ | No ☐ | Chemotherapy | Yes ☐ | No ☐ |
| Arteriosclerosis (hardening of arteries) | Yes ☐ | No ☐ | Rheumatic fever | Yes ☐ | No ☐ | Radiation Therapy | Yes ☐ | No ☐ |
| Asthma | Yes ☐ | No ☐ | Glaucoma | Yes ☐ | No ☐ | Bruise Easily | Yes ☐ | No ☐ |
| Tuberculosis | Yes ☐ | No ☐ | Liver Disease | Yes ☐ | No ☐ | Ulcers | Yes ☐ | No ☐ |
| Emphysema | Yes ☐ | No ☐ | Sickle Cell Disease | Yes ☐ | No ☐ | Pain in Jaw Joint | Yes ☐ | No ☐ |
| Sinus Trouble | Yes ☐ | No ☐ | Diabetes (Type 1 or 2?) | Yes ☐ | No ☐ | Dry mouth | Yes ☐ | No ☐ |
| Hay Fever (seasonal allergies) | Yes ☐ | No ☐ | Hepatitis A (infectious) | Yes ☐ | No ☐ | | | |
| Allergies or Hives | Yes ☐ | No ☐ | Hepatitis B (serum) | Yes ☐ | No ☐ | | | |
| Chronic Cough | Yes ☐ | No ☐ | Hepatitis C | Yes ☐ | No ☐ | | | |
| Epilepsy or Seizures | Yes ☐ | No ☐ | Artificial Joints (Hip, Knee, etc.) | Yes ☐ | No ☐ | | | |

Are you now taking any medication, drugs, or pills? ☐Yes ☐No

**If yes, please list all current medications in the chart below.**

| MEDICATION NAME | HOW OFTEN IS IT TAKEN? | WHAT IS THIS MED. TAKEN FOR? |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |

**For Women Only:**

Are you pregnant? ☐ Yes ☐No

If yes, what is your due date? _____

If yes, list your OB/GYN's name and phone number. _____

Are you nursing? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No

**I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully.**

Patient Signature: _____ Date: _____

Staff's Signature: _____ Date: _____



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Patient Name: _____ DOB: _____

**Consent, Release and Statement to Permit**
**Payment of Medicare/Private Insurance Benefits of Provider**

I voluntarily consent to routine medical treatment by SWLA Center for Health Services for myself or the above named minor, for whom I am parent/guardian. I understand that specific and separate consent will be requested from me prior to any non-routine, hazardous or major treatment that is not of any emergency nature.

I authorize the release of information from the medical records of the above named person only to the extent necessary to carry out the following purposes, fiscal and accounting use, consultation and referral, quality assurance, educational programs and research maintaining confidentiality and previously approved by the Board of Directors of SWLA Center for Health Services.

I request payment of authorized Medicare/Private Insurance benefits for me or on my behalf for any service furnished me by or in SWLA Center for Health Services, including physician services, to SWLA Center for Health Services. I authorize any holder of medical or other information about me to release to Medicare/Private insurance and its agents any information needed to determine these benefits for related services.

I understand that if I do not qualify or apply for the Sliding Fee Discount, I am responsible for the Medicare co-payments and Private Insurance co-payments and deductibles.

**I declare that the information listed above is accurate and complete.** I understand that I may be asked for evidence to verify the statement of income and family size.

_____ _____
Signature of Patient, or Patient's Representative Date

……

**Patient Confidentiality**

Due to patient confidentiality, we are unable to relay any information regarding your healthcare to anyone but you, including husband and wife. Therefore, when a question arises regarding your appointments, billing, test results, or medical advice in general, we will only respond to you unless we are given prior permission to give information out to other people as indicated below. Should you choose that we do not disclose any information regarding you, your condition, your financial or medical records please indicate that by writing NONE. You have my permission to discuss any information held in my medical record to:

Name: Relationship:

_____ _____

_____ _____

_____ _____
Signature of Patient, or Patient's Representative Date

……

**Patient Acknowledgment of Receipt**

I, _____, hereby acknowledge that I have received a copy of the following:

- Patient Bill of Rights
- Patient Responsibilities
- Notice of Privacy Practices

_____ _____
Signature of Patient, or Patient's Representative Date

# MEDICATION HISTORY CONSENT

**Medication History:**

Up-to-date medication history information is very important in helping us provide the highest quality medical care and avoid potentially dangerous drug interactions.

A medication history is a list of prescription medicines that we or other doctors have prescribed for you. This list is collected from several sources including your pharmacy and/or insurance company and may include medications used to treat mental health conditions or HIV.

By signing this consent form, you give permission for SWLA Center for Health Services to use e-prescribing tools to obtain your medication history. You may cancel this consent at any time. However, any medication information already added to your medical record due to this consent will remain as part of your record.

Accepted: _____ (initial)

Printed Name: _____ DOB: _____

Signature: _____ Date: _____
Patient, Parent or Guardian (if patient 17 years of age or under)

Relationship to patient (if applicable): _____

……

**Request to Withdraw Consent**

Printed Name: _____ DOB: _____

Signature: _____ Date: _____

Patient, Parent or Guardian (if patient 17 years of age or under)

Relationship to Patient (if applicable): _____

# PATIENT/PARENT ATTESTATION

## LOUISIANA HEALTH INFORMATION EXCHANGE OPTION

**(please check one option)**
**[ ] Opt-In to LaHIE**
When you seek medical treatment at an organization participating in LaHIE, your health information is accessible.

**[ ] Opt-Out of LaHIE**
If you choose to opt out of LaHIE, your health information cannot be accessed through LaHIE, even in an emergency.

**[ ] No Option selected**
**If you have a health emergency, and your consent has not been obtained, your electronic health information may be accessed for emergency treatment purposes only.**

_____ Date: _____
Signature of Patient

_____ Date: _____
Printed Name of Patient

_____ Relationship: _____
Signature of Parent/Legal Guardian

_____ Date: _____
Printed Name of Parent/Legal Guardian

This consent may be withdrawn or modified at any time with written permission of the patient or parent/guardian to the entity referred to above. A duplicate copy of this document will be given to parents or guardians upon request.

**SWLA WITNESS**

| _____ | _____ | _____ |
|---|---|---|
| Printed Name | Signature | Date |

# PATIENT RESPONSIBILITY FORM

***It is important that you read and acknowledge our patient responsibility policy in full.***

Payment is due in full at the time services are rendered. As the patient/guarantor, you are financially responsible for any fees and costs associated with any services you received from our office. This includes any medical/dental visits, ultrasounds, labs and any other services ordered by the doctor or staff.

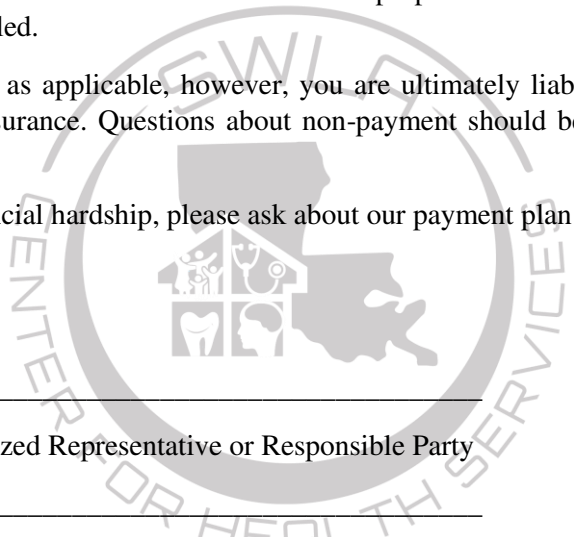
Co-payments /Sliding Fee payments will be collected at the time of service.

As a patient/ guarantor, it is your responsibility to know your insurance benefits and to provide our office with accurate and current insurance information. If you arrive for an appointment and your insurance is inactive, you have the option to reschedule the appointment, be placed on our Sliding Fee discount program or pay in full for all services rendered.

If you are a patient with a secondary insurance to your primary plan, it is your responsibility to provide both insurance identification cards. If the office does not have the proper information for a secondary insurance, the secondary will not be billed.

We will bill your insurance as applicable, however, you are ultimately liable for any fees and cost not covered or paid by your insurance. Questions about non-payment should be directed to your insurance company.

If you are experiencing financial hardship, please ask about our payment plan agreement.



_____ _____

Signature of Patient, Authorized Representative or Responsible Party Date

_____ _____

Print Name of Patient, Authorized Representative or Responsible Party Relationship to Patient

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# Sliding Fee Application

Name _____ DOB _____ Date _____/_____/_____

Completion of this form must be accompanied by proof of eligibility for a sliding fee discount. This application is available to ALL persons without regard to race, creed, color, age, and religion, country of origin, sexual orientation, any disability, or ABILITY TO PAY. ALL SLIDING FEE APPLICATIONS WILL BE PREPARED BY THE ELIGIBILITY STAFF TO DETERMINE THE DISCOUNTED AMOUNT ACCORDING TO THE INCOME AND FAMILY SIZE. A copy of application will be filed and the information documented in the patients HER and on their account entry in SWLA's database. SUBMITING FALSE INFORMATION ON THIS APPLICATION MAY RESULT IN YOUR BEING DENIED THE SLIDING FEE DISCOUNT.
____ (patient initials)

| Names of Family members | D.O.B. | Names of Family members | D.O.B. |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Signature _____ Date _____

***Statement of No Income***

I am applying of the SWLA Center for Health Services Sliding Fee Discount Program on _____ (date). I affirm that I have no income and I am currently unemployed. I acknowledge that it is my responsibility to return once I secure gainful employment and provide proof of my income and update my sliding fee application. If there is no change in my income status, I will need to reapply for the program annually on the date of _____/_____/_____.
Signature _____ Date _____

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++++++++++++++++++++++++++++++++++++++++++++FOR OFFICE USE ONLY++++++++++++++++++++++++++++++++++++++++++++

Sliding Fee Scale Assignment: SFA _____ SFB _____ SFC _____ SFD _____ SFE _____

STAFF signature _____ Date _____

**** This completed application is valid for 12 months***

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# ADULT/MINOR GENERAL DENTAL CONSENT FORM

Print Patient's Name _____ D.O.B _____/_____/_____

I hereby voluntarily consent to dental examination, treatments and/or procedures including laboratory test and x-rays, which are deemed necessary in the opinion of my dentist. I understand that the dental residents, dentists or students and hygienists may perform the above procedures.

I have been given an opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks of no treatment, the procedure to be used and the risks and hazards involved, and I have sufficient information to have this informed consent. My signature acknowledges that I have been given the opportunity to satisfy myself by asking questions about this consent form.

I understand that no guarantees or warranties have been made to me concerning the results of the examinations, treatments, or procedures. I understand that successful treatment often depends upon my cooperation in the following my doctor's instructions. I agree to follow my doctor's instructions completely and to fully cooperate in my care, including keeping and necessary additional appointments with my doctor, to enhance the possibility of successful treatment outcomes.

I understand that the dentist and/or staff of the SWLA Center for Health Services are available to patients once treatment has begun, when clinic is open and available for after hour's consultations or advice in the event of emergency only. After hours, if I have a questions regarding my treatment at SWLA Center for Health Services, I understand that I should call the main number, 337-439-9983 in Lake Charles, and ask for a doctor on call.

_____

Signature of Patient, Parent or Guardian

Today's Date _____/_____/_____

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**Consent for Commonly Performed Procedures at**
**SWLA Center for Health Services**

I understand some possible risks of dental treatment are:

1. **Local Anesthesia:**
   A. Injury to nerve; transient or permanent numbness and tingling sensations in lip, tongue, chin, gums, cheeks, and/or teeth.
   B. Allergic reaction.
   C. Cheek biting until numbness subsides.
   D. Inadequate level of anesthesia. **Pt. Initials _____**

2. **General Operative Procedures:**

   A. Non-invasive Excavation of Decay:
      1. Mechanical pulpal exposure needing additional procedures.
      1. Galvanic shock after restoration.
      2. Transient sensitivity. **Pt. Initials _____**

   B. Invasive Excavation of Decay:
      1. Transient post-operative sensitivity;
      2. Inability to restore without additional dental procedures (root canal therapy, extraction).
      3. Mechanical pulpal exposure.
      4. Carious pulpal exposure. **Pt. Initials _____**

3. **Periodontal Therapy:**
   A. Prophy
      1. Transient sensitivity.

   B. Scaling and Root Planning
      1. Post-Operative discomfort and swelling that may temporarily persist.
      2. Stretching of the corner of the mouth with resultant cracking and bruising.
      3. Swelling, bruising and bleeding of gum tissue.
      4. Shrinkage of gum tissue.
      5. Sensitivity of the teeth.
      6. Loosening of the teeth.
      7. Fracture of existing restoration.
      8. Exposure of margins of crowns. **Pt. Initials _____**

Special Comments: _____

_____

# Non-Covered Services Form

Non-Covered Services Member Commitment Form or Private Pay Commitment Form

**SWLA Center for Health Services (Circle One):** **CROWLEY** **LAFAYETTE** **LAKE CHARLES** **OBERLIN**

Provider Name: _____

Office Phone Number **(Circle One)**: **C (337) 783-5519** **L (337) 769-9451** **LC (337) 439-9983** **O (337) 639-2281**

Patient's Name: _____ Date: _____

Account#: _____ Date Treatment Plan Created: _____

***This signed form is required to be kept as part of the member's dental chart**.

| **Procedure (s)** | **Tooth / Arch** | **Fee w/o Sliding Fee Discount** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | **Total** | **$** |

Member ID: _____ Member Name: _____

**Signed By Name (*Member, Parent or Guardian):** _____

**Respond YES or NO Applicable Below**

| | | |
|---|---|---|
| My dentist advised me that there are NO covered services that would take care of my dental concern. | YES | NO |
| My dentist advised me that there Are covered services that would take care of my dental concern, but I AM refusing to select these. | YES | NO |
| I understand I have to pay the total amount for any of these services and My Insurance will not pay any portion of the cost. | YES | NO |

***I agree to pay for these dental services if I fail to make each payment I may be subject to collection action.**

_____ Date: _____

***Patient Signature if over (18) or Parent or Guardian**