ACCESS FAMILY CARE
Medical & Dental Clinics

MOBILE DENTAL REGISTRATION FORM

Date_____

As a Federally Qualified Health Center, we are required by the Bureau of Primary Health Care to collect data on all our patients. ACCESS does not discriminate based on age, sex, race, creed, marital status, religion, national origin, disability, sexual preference, public assistance status or criminal record.

P L E A S E P R I N T

PATIENT NAME_____Social Security No._____
Last First Middle

Date of Birth_____ Gender: ☐Male ☐Female ☐Other ☐Decline

School Name: _____ Grade:_____

Mailing Address_____
City_____ State_____ Zip_____ Physical
Address (if different)_____ County of Residence_____
City_____ State_____ Zip_____ Home
Phone_____ Cell/Alternate Phone_____ Primary E-mail
Address_____ Do you use the Patient Portal: ☐Yes ☐No
Legal Guardian (if patient is 17 or under) _____
Legal Guardian Phone #: _____
Name of Secondary Contact_____ Secondary Contact Phone_____
(family, friend or neighbor, not living with you, who can get a message to you)
Relationship to Secondary Contact_____
Preferred Pharmacy_____ Location_____

Preferred Language: ☐English ☐Spanish ☐Other_____
(indicate which language)

Language assistance. If you need such assistance, please check what kind of assistance you require.
☐ Sign Language ☐ Visual Aides

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino

Race: Please check ALL that apply: ☐White ☐Black/African American ☐American Indian or Alaska Native ☐Asian ☐Native Hawaiian ☐Other Pacific Islander ☐More than one race ☐Decline to Answer

MEDICAL HISTORY

Asthma	☐ Yes ☐ No	Recent Toothache	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No	Artificial Heart Valve	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Congenital Heart Defect	☐ Yes ☐ No
Seizures/Epilepsy	☐ Yes ☐ No	Rheumatic Heart Disease	☐ Yes ☐ No
Bleeding Problems	☐ Yes ☐ No	Other	☐ Yes ☐ No

Any Surgeries / Other / Explain:_____
Does your child have any allergies? ☐ Yes ☐ No
If yes, please explain: _____
List any medications your child is taking: _____

DENTAL HISTORY

Any dental concerns for your child? _____

Has your child seen a dentist before? ❑ Yes, in the past year ❑ Yes, more than 1 year ago ❑ No

CONSENT FOR DIAGNOSTIC AND PREVENTIVE TREATMENT & ASSIGNMENT OF BENEFITS

Check the box below that you give permission for your child to receive:

❑ **DENTAL**: I/We consent for my/our child to receive dental preventive services in ACCESS's portable school clinic. Dental preventive services include but are not limited to screenings, fluoride, exam, x-rays, and sealants. I understand this consent is valid for 1 year from the date of signature.

Assignment of Benefits: I/We understand that eligible services may be billed to Medicaid and/or private insurance. I hereby instruct and direct all proceeds of insurance to be paid to ACCESS to be paid by check for the dental and/or medical expense benefits allowable, and otherwise payable to me, under my current insurance policy as payment toward the total charges for the professional services rendered. I/We authorize ACCESS to release or receive information on eligibility and/or benefit information for the purpose of filing insurance claims. I also understand that additional information may be needed from my file to achieve maximum benefits. I/We acknowledge receipt of the HIPAA Notice of Privacy Practice attached to this consent form. I understand this consent is valid for 1 year from the date of signature. I understand that consent may be revoked at any time upon my request. Further, I/We as the applicant's parent(s) or guardian(s) authorize ACCESS or individuals designated by ACCESS to act for me/us in an emergency, accident or illness.

_____ Date: _____

Signature of Parent/Guardian

INSURANCE or MISSOURI HEALTH NET INFORMATION (please fill out and/or include a copy of card)

Name of Dental Insurance:_____ Employer:_____

Name of Policy Holder: _____ DOB: _____ Group #_____

Policy# / Subscriber ID: _____ SSN #: _____ Insurance Phone #_____

Insurance Address _____

Medicaid / MO HealthNet Number: _____

Mobile Dental Patient Balance Assistance Form

This form qualifies your child to receive monetary assistance through charity care grant funds for the balance of the patient's (student's) bill when receiving in school portable dental services. If this form is not completed the remaining balance will be billed to the parent's address.

Patient's Name: _____

Patient/Legal Guardian: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Name of School:_____ Grade:_____

I request assistance with the patient balance for school-based dental services received for the above named patient.

_____ _____

Parent/Legal Guardian Signature **Date**

- Anderson Dental: 417-845-2273 Joplin Dental: 417-782-0080
- Cassville Dental: 417-847-0057 Neosho Dental: 417-451-0977
- Carthage Dental: 417-674-2141