HAWSE HEALTH CENTERS
REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Birth Date:	Sex: ☐ Male ☐ Female	Social Security Number:

PO Box:	Street:	City:	State:	Zip Code

Parent/Guardian Name: If Patient is a minor, mother's maiden name:	Home Phone# ____ Cell Phone# ____ **Best Daytime Phone#** ____	Parent/Guardian Date of Birth:	Parent/Guardian Social Security#
Street Address: PO Box:	City:	State:	Zip Code:

Marital Status: Single☐; Married☐; Divorced☐; Separated☐; Widow☐
Race: White☐; Black/African American☐; American Indian/Alaskan Native☐; Asian☐; Native Hawaiian/Other Pacific Islander☐; Other☐; Declined☐
Ethnic Origin: Hispanic or Latino☐; Not of Hispanic or Latino Origin☐; Declined☐;
Language: English☐; Spanish☐; Other☐____
Sexual Orientation: Straight☐; Bisexual☐; Lesbian or gay☐; Something Else ☐; Don't know ☐; Chose not to disclose ☐
Gender Identification: Male☐; Female☐; Transgendered Male/Female☐; Transgendered Female/Male☐; Declined☐; Other☐____
Veteran Status: Veteran☐; Active Duty☐; None☐
Homeless Status: Homeless Shelter☐; Transitional☐; Doubling Up☐; Street☐; Not Homeless☐; Other☐; Declined☐
Poverty Level: Unknown☐; <=100%☐; 101-150%☐; 151-200%☐; >200%☐
Worker Status: Migrant☐; Seasonal☐; Retired☐; Student☐; Declined☐; Unemployed☐
Employed☐; **Employer/Phone#** ____

Patient ☐will enroll in Sliding Fee Program. **OR** Patient ☐will not enroll in Sliding Fee Program and has declined coverage.

Email: ____

Pharmacy of choice: ____

IF WE ARE UNABLE TO CONTACT YOU, WHO SHOULD WE CALL:

Name: ____ Phone# ____ Relationship to Patient: ____

Name: ____ Phone# ____ Relationship to Patient: ____

INSURANCE INFORMATION

(Please give your insurance cards to the receptionist)

Is this patient covered by insurance? ☐Yes ☐No		Name of Primary Insurance:			
Subscriber's name:	Subscriber's S.S. no.:	Birth Date:	Group no:	ID no:	Co-Payment: $

Subscriber's Address:	Home Phone: ( )

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Patient's relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other

Name of Secondary insurance (if applicable):	Subscribers name:	Group no:	ID no:

Patient's relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to E. A. Hawse Health Center. I understand that I am financially responsible for any unpaid balance. I also authorize E. A. Hawse Health Center to release any information required to process my insurance claim. I authorize E. A. Hawse Health Center's Medical, Dental, Behavioral Health staff to consult together and to perform needed treatments and/or diagnostic tests for necessary care including Medical, Dental or Behavioral Health services.

____ *Patient/Guardian Signature*

____ *Date*

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Updated 8/8/2016; Updated 8/13/18
Updated 7/16/2019; 7/29/19

DENTAL HISTORY

HAWSE HEALTH CENTER

Garrett Long, DDS
Sierra Hardy, DDS
PO Box 97
Baker, WV 26801
304-897-5915

Sierra Hardy, DDS
111 S. Grove Street, Suite 1
Petersburg, WV 26847
304-257-4593

Patient Name: ______________________________
Reason for visit today? ______________________________

Are any of your teeth sensitive to hot or cold? Yes No
Are any of your teeth sensitive to sweet? Yes No
Any sensitivity to biting or chewing pressure? Yes No
Do you notice mouth odors? Yes No
Do you notice bad taste? Yes No
Do your gums bleed or hurt? Yes No
If yes, how often? ______________________________
Does food get caught between your teeth? Yes No
Is this a problem you want corrected? Yes No
Do you clench or grind your teeth? Yes No
Do you even notice tired jaws or sore teeth? Yes No
Do you smoke or chew tobacco? Yes No
Are your currently missing any teeth? Yes No
Is this a problem you want corrected? Yes No
Have you ever had braces? Yes No
Have you ever had oral surgery? Yes No

Have you ever had periodontal surgery? Yes No
Do you wear a bite or "night" guard? Yes No
Any serious injury to the mouth or head? Yes No
Please describe: ______________________________
____
Does your jaw click or pop? Yes No
Any pain in your jaw joint? Yes No
Frequent headaches? Yes No
Frequency and time of day of headaches: __________
____
Do you feel nervous about dental treatment? Yes No
If so, what are your concerns: __________________
____

Date of: Last Dental Visit? ______________ Last Cleaning? ______________ Last X-Ray's? ______________
What was done at your last dental visit? ______________________________
____
Previous Dentists Name: ______________________________ Phone # ______________
Your reason for leaving their office: ______________________________
What did you *like* about your previous dental experiences? ______________________________
What did you *dislike* about your previous dental experiences? ______________________________
How often do you normally have dental examinations? Once per year Twice per year Three times per year More
How often would you prefer dental examinations? Once per year Twice per year Three times per year More
Would you like to discuss your options to enhance your smile? (i.e. whiter, straighter teeth). Yes No

If yes, what are your goals and expectations? ______________________________
Are you concerned about your silver-mercury fillings? Yes No
Is there anything else/other dental concerns we have not asked about that you want us to know? ______________
____
How can we make each of your future visits more enjoyable? ______________________________
____

Notes: ______________________________
____
____

PLEASE COMPLETE THE OTHER SIDE. THANK YOU.

MEDICAL HISTORY

Patient Name: ______________________________

Have you been under the care of a medical doctor in the past two years? Yes No
If yes, please explain: ______________________________
Physician's name: ______________________________ Phone # ______________
List any medications or pills you take now, or have taken in the last 6 months: ______________
____
List any medications or antibiotics you have had an adverse or allergic reaction to: ______________
____

Indicate which of the following you have had or have at present.

Heart (surgery, disease, attack)	Yes No	Chest Pain	Yes No
Congenital heart disease	Yes No	Heart murmur	Yes No
High blood pressure	Yes No	Mitral valve prolapse	Yes No
Artificial heart valve	Yes No	Rheumatic fever	Yes No
Cortisone medicine	Yes No	Stroke	Yes No
Special/restricted diet	Yes No	Artificial joints	Yes No
Kidney trouble	Yes No	Ulcers	Yes No
Diabetes	Yes No	Thyroid problems	Yes No
Latex allergy	Yes No	Radiation therapy	Yes No
Chemotherapy	Yes No	Tumors removed	Yes No
Hepatitis A, B, or C	Yes No	Venereal disease	Yes No
A.I.D.S.	Yes No	H.I.V. positive	Yes No
Blood transfusions	Yes No	Hemophilia	Yes No
Sickle cell disease	Yes No	Liver disease	Yes No
Yellow jaundice	Yes No	Epilepsy or seizures	Yes No
Fainting or dizzy spells	Yes No	Psychiatric care	Yes No

Do you have any other disease or condition not listed? Yes No If yes, please list: ______________
____

Women: Are you: Pregnant? Yes No Nursing? Yes No 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 to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, which may release such information to you. I will notify the doctor of change in my health or medication.

Patient/Parent/Guardian Signature ______________________________ Date: ______________

DO NOT DATE UNTIL AT YOUR APPOINTMENT

History Review:

Dentist Signature: ______________________________ Date: ______________

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(304) 897-5915
FAX (304) 897-6216
PO Box 97
Baker, WV 26801
HAWSEHEALTH.COM

Acknowledgements

I acknowledge that I have received and understand E. A. Hawse Health Center's *Payment and Scheduling Policies*. I further understand that E. A. Hawse Health Center may update these policies any time and that I may receive an updated copy by submitting a request in writing.

I acknowledge that I have received and understand E. A. Hawse Health Center's *Notice of Privacy Practices* containing a description of the uses and disclosures of my health information. I further understand that E. A. Hawse Health Center may update its *Notice of Privacy Practices* at any time and that I may receive an updated copy of E. A. Hawse Health Center's *Notice of Privacy Practices* by submitting a request in writing.

I give permission for E. A. Hawse Health Center to release information (including my medical or behavioral health chart/EHR) to the following:

NAME	RELATIONSHIP	PHONE NUMBER

If your child needs to be seen at school or at one of our offices, please list anyone who has permission to bring your child for medical or behavioral health treatment:

NAME	RELATIONSHIP	PHONE NUMBER

May we leave medical information such as test results on your answering machine? ☐Yes ☐No

______________________________ __________________________
Printed Patient Name Date of Birth

______________________________ __________________________
Patient Signature Date

If completed by patient's personal representative, please print and sign below.

______________________________ __________________________
Printed Patient Personal Representative Name Relationship to Patient

______________________________ __________________________
Patient Personal Representative Signature Date

☐ Please keep this signature on file should I have to pay for services using my credit card

For E. A. Hawse Health Center Official Use Only

Complete this form if unable to obtain signature of patient or patient's personal representative. E. A. Hawse Health Center made a good faith effort to obtain patient's written acknowledgement of the Payment and Scheduling Policies and Notice of Privacy Practices but was unable to do so for the reasons documented below:

☐ Patient or patient's personal representative refused to sign ☐ Other
☐ Patient or patient's personal representative unable to sign

______________________________ __________________________
Printed Employee Name/Signature Date