Patient Registration

Date: _____

First Name	MI	Last Name
Nickname	Date of Birth (MM-DD-YYYY)	
Social Security Number		
Street Address	Apartment #	

City	State	Zip Code	County
Phone Number	Email Address		

Gender
☐ Male ☐ Female
☐ Transgender Female to Male
☐ Transgender Male to Female
☐ Does not identify as any above
☐ Other:
_____

Ethnicity
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Race
☐ American Indian or Alaskan Native
☐ Asian ☐ White
☐ Black or African American
☐ Pacific Islander or Native Hawaiian
☐ Unsure ☐ Some Other Race:
_____

Family Type
☐ Single ☐ Two Parent Household
☐ Single Parent/Female ☐ Single Parent/Male
☐ Two Adults/No Children
☐ Other: _____

Housing Status
☐ Disabled ☐ Unhoused
☐ At risk of Losing Housing ☐ Fleeing Domestic Violence
☐ Stably Housed - Rent ☐ Stably Housed - Own
☐ Other: _____

Reason for Assistance
☐ Not Working or Seeking Work ☐ Sudden Job Loss ☐ Unable to find employment ☐ Non-livable wage
☐ Crime victim ☐ Medical Short/Long Term ☐ Eviction ☐ Moving or Newly Relocated
☐ Caring for sick or disabled family ☐ Dental emergency/unmet needs ☐ Weather or Natural Disaster
☐ Family Disruption ☐ Fire ☐ Homelessness ☐ Other: _____

Employment
☐ Full Time ☐ Part Time
☐ Not Working ☐ Disabled
☐ Retired ☐ Other:
_____

Relationship Status
☐ Married ☐ Single
☐ Widowed ☐ Partnered
☐ N/A (under 18)

Education
☐ College ☐ Some College
☐ High school diploma or GED
☐ High school - incomplete
☐ Middle school ☐ No school

Primary Language Spoken at Home:

Military Status ☐ Active Status ☐ Veteran ☐ No Service

Medical History

Are you currently under the care of a physician? ___Yes ___No

If yes, what is the physician's name:_____

Have you ever been hospitalized or had a major operation? ___Yes ___No

If yes, please explain: _____

Have you ever had a serious head or neck injury? ___Yes ___No

If yes, please explain: _____

Are you taking any medications? ___Yes ___No

If yes, please list: _____

_____

Are you currently taking a blood thinner? ___Yes ___ No Drug name:_____

Are you currently taking any bisphosphonates? ___Yes ___No Drug name: _____

Do you use tobacco? ___Yes ___No

Do you use controlled substances? ___Yes ___No

Are you pregnant? ___Yes ___ No If yes, when are you due? _____

Currently Nursing? ___Yes ___No

Are you allergic to any of the following:

___Aspirin ___Penicillin ___Codeine ___Acrylic

___Metal ___Latex ___Sulfa Drugs ___Local Anesthetics

Other Allergies? Please list: _____

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

___AIDS/HIV Positive	___Cortisone Medicine	___Stroke
___Alzheimers	___Diabetes	___Thyroid Disease
___Anaphylaxis	___Epilepsy/Seizures	___Tonsillitis
___Anemia/Blood Disease	___Hepatitis	___Tuberculosis
___Angina/Chest Pains	___Kidney Problems	___Tumors
___Arthritis/Gout	___High/Low Blood Pressure	___Ulcers
___Artificial Heart Valve	___High Cholesterol	___Venereal Disease
___Artificial Joint	___Osteoporosis	___Sinus Troubles
___Ashtma/Emphysema	___Pain in Jaw Joints	___Heart Disorders
___Cancer	___Psychiatric Care	___Shingles
___Chemotherapy	___Rheumatism	___Cold Sores

Have you ever had any serious illness not listed above? ___Yes ___No

If yes, please explain: _____

_____

Patient Signature:_____ Date:_____

Notice of Privacy Practices

The Seton Center Dental Clinic provides a detailed explanation of your rights and the practices guiding how information in the Seton Center Dental Clinic database is treated.

By signing this form you acknowledge that you have been offered and/or received a copy of the Notice of Privacy Practices, and have had an opportunity to review the Seton Center Dental Clinic Notice of Privacy Practices.

Patient Signature:_____ Date:_____

Consent for Treatment

I authorize the Seton Center Dental Clinic dentist or other authorized staff, to provide treatment and/or consultation deemed appropriate for my care or care of my child. Furthermore, I understand that all medical documents, including x-rays, shall remain property of the Seton Center Dental Clinic.

Patient Signature:_____ Date:_____

Insurance Assignments and Benefits Release

I, the undersigned, certify that I/my dependents have dental coverage and assign all authorized benefit payments to be made to the Seton Center Dental Clinic. on my behalf of my/my dependents. Furthermore, I authorize the release of any information to any private payer, third party payer, or government agency responsible for the payment of benefits related to any submitted claims on my behalf or on the behalf of my dependents. I agree to assume financial responsibility for all expenses of such care.

Patient Signature:_____ Date:_____

Seton Center Patient Expectations and Responsibilities

Welcome to the Seton Center Dental Clinic! Our goal is to provide affordable, quality health and dental services. In order to achieve this goal, we work at and depend on honest and open communication with our patients. The purpose of this document is to establish an understanding between you and the Seton Center Dental Clinic about what you can expect from each other in relation to your dental care. Please read this document as part of your enrollment process.

Patients are expected to:

- Provide complete and accurate information about yourself and your family and inform us of any changes in your information.
- **Notify us 24 hours in advance if an appointment needs to be rescheduled. After 3 missed appointments there will be a $50 fee that MUST be paid BEFORE you can be rescheduled.**
- Refuse treatment if you do not want to receive treatment.
- Treat Seton Center Dental Clinic staff with respect and courtesy.
- Payment is expected at the time of service. Arrangements need to be made **PRIOR** to your scheduled appointment.
- The patient is the **ONLY** one allowed in the operatory unless arrangements have been made **PRIOR** to the scheduled appointment.

Patient Signature:_____ Date:_____

STANDARD OF CONDUCT POLICY

Seton Center is committed to providing quality service and a safe environment to our clients and patients. The success of our organization is dependent on the trust and confidence we earn from our clients and patients. Seton Center encourages high standards of conduct and personal integrity. It is critical that our clients, patients, volunteers, and employees espouse these standards of conduct to ensure the safety of all. Disruptive behaviors not in line with Seton Center's commitment to providing a safe environment will not be tolerated and will result in further action.

DISRUPTIVE BEHAVIOR: For the purposes of this policy and procedure, disruptive behavior that compromises the safety of Seton Center patients, associates, and/or visitors is defined as follows:

A. Any actions by patients, clients or visitors at Seton Center that interfere with the functioning and flow of the workplace and/or hinders associates from carrying out their professional responsibilities
B. Physical actions short of actual contact/injury (moving closer aggressively)
C. Physical assault, with or without weapons
D. Conduct that a reasonable person would interpret as being potentially violent
E. Disruptive behavior may be exhibited in a personal encounter or deployed in any media, video, telephonic, or in written or printed form

Specific examples of Disruptive Behavior include, but are not limited to:

- Loud or profane language
- Being under the influence of drugs and/or alcohol
- Direct, indirect or implied threats
- Terroristic threat (threat to commit a violent crime that inflicts severe bodily injury on someone else or does serious damage or harm to property)
- Unwanted approaches toward others
- Persistent or intense outbursts
- Verbal abuse, such as derogatory name-calling
- Behavior that interferes with the ability of other patients to access medical care
- Sexual harassment
- Sexual assault
- Physical abuse (e.g. bumping, shoving, slapping, striking, or inappropriate touching)
- Damage to or destruction of clinic property or personal property of individuals
- Racial or ethnic epithets
- Unwanted contact toward others
- Inappropriate contact or communication with a minor
- Possession or waving of weapons

Disciplinary Action may include, but will not be limited to:

- Verbal Warning
- Suspension from Seton and services if applicable
- Meeting with Ethics & Standards committee
- Permanent ban from Seton Center premises

I acknowledge that I have read and understand Seton Center's Standard of Conduct Policy. I also understand that my eligibility to receive services from Seton Center is contingent upon adhering to Seton's Center's standard for client conduct.

Patient Signature: _____ Date: ___/___/___