Chase Brexton Health Care
Because everyone's health matters.

PATIENT REGISTRATION FORM

General Information

Patient Legal Name: _____

Name preference (How would you like to be addressed?): _____ Date of Birth:_____

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed ☐ Separated

Address: _____ ☐ I do not have a permanent address

City/State/Zip Code: _____

Phone: _____ ☐ This phone receives texts Work Phone: _____

Email Address: _____

How should we contact you? ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Text ☐ Mail ☐ E-mail

Birth/Legal Sex: ☐ MALE ☐ FEMALE Social Security Number: _____

Current care provider: _____ Phone Number: _____

☐ I do not have a current care provider

In an effort to know more about the people we serve, we would appreciate the following information:

Preferred language (if other than English): _____

Race: ☐ Black/African American ☐ White/Caucasian ☐ Asian ☐ Native Hawaiian ☐ Pacific Islander

☐ American Indian/Alaskan Native ☐ More than one race ☐ Other ☐ Decline to State

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Decline to State

Household Income: Total yearly income**:** _____ Number of people in household: _____

I am a Veteran ☐

Sexual Orientation: ☐ Straight/Heterosexual ☐ Lesbian/Gay/Homosexual ☐ Bisexual

☐ Choose not to disclose ☐ Other: _____

Current Gender Identity: ☐ Male ☐ Female ☐ Gender Queer ☐ Other: _____

☐ Transgender Male/Transman/FTM ☐ Transgender Female/Transwoman/MTF ☐ Choose not to disclose

Pronoun Preference: ☐ Male ☐ Female ☐ Other: _____

Employer: _____

Employer Address: _____

Emergency Contact Name: _____

Phone Number: _____ Relationship: _____

Special Needs such as a wheelchair, interpreter, or ambulance transportation, etc?: ☐ YES ☐ NO

If yes, please explain: _____

Chase Brexton Health Care
Because everyone's health matters.

PATIENT REGISTRATION FORM

Contacts for minors

PLEASE COMPLETE IF PATIENT IS UNDER 18 YEARS OLD OR HAS A LEGAL GUARDIAN

Parent/Legal Guardian #1 Name: _____Phone #1:_____

Parent/Legal Guardian #2 Name: _____Phone #2:_____

Address if different than patient: _____

_____

Insurance and ID

Please have your ID and insurance card ready.

If patient is a minor, please present a copy of the birth certificate or other ID.

Ask for a sliding fee scale application if interested. This may lower charges for patients making less than 200% Federal Poverty Level (around $25,000 for one person/$50,000 for four)

How did you hear about us?

☐ Billboard	☐ Health Fair/Educational Event	☐ TV
☐ Bus Ad	☐ Newspaper Ad	☐ Website
☐ Community Agency/Church/School	☐ Online/Social Media	☐ Other
☐ Family/Friend	☐ Radio	

I certify that the information contained herein is accurate. If any information changes, I will notify Chase Brexton Health Care.

Patient Signature (if over 18): _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name: _____

Office Use Only

____Responsible Provider verified/updated
____Home Location verified/updated
____Insurance information verified/updated
____Patient Alert Notes updated

Reviewed/entered into CPS by: _____ Date: _____

Chase Brexton Health Care
Because everyone's health matters.

PATIENT MEDICAL HISTORY FORM FOR DENTAL PATIENTS

Patient Legal Name: _____ Date of Birth: _____

Preferred Name: _____

Are you in good health? ☐ YES ☐ NO

Have there been any changes in your health in the past year? ☐ YES ☐ NO

Date of last physical exam: _____ Are you under the care of a physician? ☐ YES ☐ NO

Physician's Name: _____ Phone Number: _____

Address: _____

Hospitalizations/Surgeries:

_____ Date _____

_____ Date _____

_____ Date _____

Have you had any abnormal bleeding? ☐ YES ☐ NO Have you had any recent weight loss? ☐ YES ☐ NO

Have you every required a blood transfusion? ☐ YES ☐ NO Do you bruise easily? ☐ YES ☐ NO

Have you had persistent cough or throat clearing for more than 3 weeks not associated with a known illness? ☐ YES ☐ NO

Medications (include herbal, vitamins, and supplements):

Name	Dosage	Name	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever taken Fen-Phen or Redux? ☐ YES ☐ NO

Have you ever taken Fosamax, Boniva, Actonel, or any cancer medications containing Bisphosphonates? ☐ YES ☐ NO

Have you taken Viagra, Revatio, Cialis, or Lavitra in the last 24 hours? ☐ YES ☐ NO

Do you use tobacco? ☐ YES ☐ NO Do you or have you used controlled substances? ☐ YES ☐ NO

Are you wearing contact lenses? ☐ YES ☐ NO

Are you taking birth control pills? ☐ YES ☐ NO ☐ N/A

Are you pregnant or think you may become pregnant? ☐ YES ☐ NO ☐ N/A

Are you nursing? ☐ YES ☐ NO ☐ N/A

Please list any other diseases, conditions, or problems that have not been addressed on this form that we should know about:

_____

_____

Chase Brexton Health Care
Because everyone's health matters.

PATIENT MEDICAL HISTORY FORM FOR DENTAL PATIENTS

Are you allergic to have had reactions to:

	YES	NO
Local anesthetics like Novocain	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Aspirin	☐	☐
Iodine	☐	☐
Any metals (nickel, mercury, etc)	☐	☐
Latex/Rubber	☐	☐
Other _____	☐	☐

Do you have or have you ever had any of the following?

	YES	NO		YES	NO
Rheumatic health disease or rheumatic fever	☐	☐	Arthiritis or rheumatism	☐	☐
Scarlet fever	☐	☐	Joint replacement or implant	☐	☐
Heart defect or heart murmur	☐	☐	Stomach ulcer	☐	☐
Heart trouble, heart attack, or angina	☐	☐	Kidney problems	☐	☐
Chest pain	☐	☐	Tuberculosis	☐	☐
Shortness of breath	☐	☐	Persistent Cough	☐	☐
Pacemaker	☐	☐	Cough that produces blood	☐	☐
Heart surgery	☐	☐	Chemotherapy (cancer/leukemia)	☐	☐
High or low blood pressure	☐	☐	Sexually transmitted disease	☐	☐
Congenital heart problems	☐	☐	Epilepsy or seizures	☐	☐
Swelling of feet, ankles, or hands	☐	☐	Anemia	☐	☐
Hepatitis, jaundice, or liver disease	☐	☐	Glaucoma	☐	☐
Stroke	☐	☐	Nervousness	☐	☐
Sinus trouble	☐	☐	Tonsilitis	☐	☐
Lung or breathing problems	☐	☐	Tumor(s)	☐	☐
Asthma or hay fever	☐	☐	Back problems	☐	☐
Hive or skin rash	☐	☐	Mental health care	☐	☐
Fainting or dizzy spells	☐	☐	Chemical dependency	☐	☐
Diabetes	☐	☐	Mitral Valve prolapse	☐	☐
AIDS or HIV infection	☐	☐	Cortisone treatment	☐	☐
Thyroid problems	☐	☐	Hypoglycemia	☐	☐
Allergies	☐	☐	Eating disorder	☐	☐
Cold sores or fever blisters	☐	☐			

Patient Signature: _____ Date: _____

Chase Brexton Health Care
Because everyone's health matters.

PATIENT DENTAL HISTORY FORM

Patient Legal Name: _____ Date of Birth: _____

Name preference (How would you like to be addressed?): _____

What is the reason for your visit today? _____

When was your last dental visit? _____

What was done at that visit? _____

Have you had a complete set of dental films (x-rays) taken? YES ☐ NO ☐

If your previous dental visit(s) and/or dental films were with another office, please make sure to complete a Release of Information (ROI) so we can obtain your records.

How often do you visit the dentist? _____

How often do you brush your teeth? _____ How often do you floss? _____

Is your drinking water fluoridated? YES ☐ NO ☐

	YES	NO
Do your gums bleed while brushing or flossing?	☐	☐
Are your teeth sensitive to hot/cold liquids/foods?	☐	☐
Are your teeth sensitive to sweet/sour liquids/foods?	☐	☐
Do you feel pain to any of your teeth?	☐	☐
Do you have any sores/lumps in/near your mouth?	☐	☐
Have you had any head, neck, or jaw injuries?	☐	☐
Have you experienced any of the following problems in your jaw:		
Clicking?	☐	☐
Pain (joint, ear, or side of face)?	☐	☐
Difficulty opening or closing?	☐	☐
Difficulty chewing?	☐	☐
Do you have frequent headaches?	☐	☐

	YES	NO
Do you clench or grind your teeth?	☐	☐
Do you bit your lips or cheeks frequently?	☐	☐
Have you noticed any loose teeth?	☐	☐
Does food become caught between your teeth?	☐	☐
Have you ever had periodontal treatment?	☐	☐
Have you had any difficult extractions?	☐	☐
Have you had any prolonged bleeding following extractions?	☐	☐
Do you wear dentures/partials?	☐	☐
If yes, what was the placement date? _____		
Have you received oral hygiene instructions regarding care of your teeth and gums?	☐	☐

Is there anything about your smile you would like to change? _____

_____

Patient Signature: _____ Date: _____

Approved 3/23/17

Chase Brexton Health Care
Because everyone's health matters.

DENTAL PATIENT EXPECTATIONS

Patient Legal Name: _____ Date of Birth: _____

Name preference (How would you like to be addressed?): _____

Our Dental Clinic:

Welcome to Chase Brexton Dental Services! We provide comprehensive, quality dental care in a compassionate and respectful environment. Our facility participates with multiple teaching institutions such as University of Maryland Baltimore College of Dental Surgery, Baltimore City Community College, and Lutheran Medical College. Our clinical dentists provide faculty supervision to dental students or residents. Our dentists over-see all treatment to ensure that care is provided at a level of quality and satisfaction consistent with Chase Brexton expectations.

Our Expectations:

It is expected that all scheduled dental appointments be kept. If you cannot keep a scheduled appointment, we expect that you cancel or reschedule with 24 hours notice.

We expect our patients to be respectful to all clinical and support staff during dental visits. We offer general dental services to diverse patient populations including multi-cultural, ethnic, racial, sexual orientation, HIV status, gender, and religious or socio-economic standings. Our clinical and support staff reflects our policy on diversity and non-discrimination and meet organizational standards for clinical and cultural competency. We treat all patients equally; with respect and care regardless of their personal background, health history, or socio-economic standing.

I understand that a violation of these expectations as well as unacceptable or disruptive behavior may lead to being discharged from dental services at Chase Brexton.

Patient Signature: _____ Date: _____

Chase Brexton Health Care
Because everyone's health matters.

PATIENT ACKNOWLEDGEMENT FORM

Patient's Financial Responsibility and Permission to Release Medical Billing Data Related to a Claim

I hereby accept financial responsibility to pay Chase Brexton all amounts not covered by my health plan, including amounts for copayments, coinsurance, fee scale payments, deductibles, non-covered services and services for which I have not received a proper authorization or a referral. In addition, I accept financial responsibility for any health care benefits that are denied because I am not eligible to receive those benefits at the time of service.

I understand that Chase Brexton accepts payment by cash, credit card, money order or check. Payment is generally required for all services at the time the services are rendered, although Chase Brexton reserves the right to later send you an invoice for health benefits that may be denied by your health plan.

I authorize my health plan to make payment to Chase Brexton for services rendered. I also authorize Chase Brexton to use and disclose my health information as necessary to obtain payment. I understand that Chase Brexton will hold me financially responsible if I choose not to have my health plan cover a service.

If my health plan is subject to ERISA, I authorize Chase Brexton to act on my behalf to obtain payment for benefits. I also authorize Chase Brexton to appeal any denial of services or benefits by any health plan on my behalf. If my account is sent to a collection agency for non-payment, I agree to pay all reasonable fees that are charged to collect the outstanding amount that is due to Chase Brexton, including reasonable attorney's fees, interest and court costs.

General Consent to Treatment

I, or my legal representative on my behalf, agree to have Chase Brexton's health care practitioners provide evaluation and treatment for my condition, injury or illness.

Acknowledgement

By signing below, I acknowledge that I have carefully reviewed this form, have had the opportunity to ask questions, and voluntarily agree to its provisions.

I have also received the Patient Handbook, which contains the

- **Notice of Privacy Practices,**
- **Patient Rights and Responsibilities, and**
- **How to communicate feedback (compliments, complaints, and grievances.)**

Patient Legal Name (printed):_____DOB:_____

Name preference (How would you like to be addressed?): _____

Signature of Patient or Legal Representative:_____Date:_____

* A copy of this Acknowledgement is available upon request.