Non-Profit Integrated Community Health Center

430 Main Street, Bethel / PO Box 1908 Bethel, AK 99559
Ph: (907)543-3773 Fax: (907)543-3545
www.bethelfamilyclinic.org

Patient Registration Record:

Last Name:____________________First Name:________________________ Middle Name: ______________

SSN:______________________Date of Birth:______________________Marital Status: M W D S

Mailing Address:_________________________City:_____________State:_________Zip:________________

Physical Address:_________________________City:_____________State:________Zip: _______________

Home Phone: (__)_________-________Work Phone: (__)_____-__________Cell Phone :(___)_____-_______

Preferred Method of Communication:___Home___Work___Cell

Email Address:____________________________Employer:______________________Date of Hire: _____________
Occupation:_______________________________

Patient Demographic Information:

Our federal grant requires us to collect and report on this information. The information is reported on the population as a whole, not by specific individual.

RACE: **(Please Check)** ___ White ___Black/African American ___ Alaska Native/American Indian

____Asian ___Native Hawaiian ____Other Pacific Islander
____Other ___Unknown ____More than one race

Ethnic Identity:____Hispanic/ Latino ___Other
Veteran:___Yes No Veteran Status:______Yes No (have you been discharged from the U.S military?)
Primary Language:____English ___Other: please identify_______________________________________
Interpreter Required? ☐ Yes ☐ No

Gender Identity: **(Please Check)** ___Male____Female
__Female-to-male/ Transgender/Trans Man __Male-to Female (MTF)/Transgender Female/Trans Woman

__Gender queer, neither exclusively male nor female __Additional Gender Category/ (or other), please specify

__Decline to Answer

Sexual Orientation: __Lesbian, Gay, or homosexual __Straight or Heterosexual
___Bisexual ___Something else___Don't Know___Decline to Answer

Emergency Contact:
First/Last Name:_____________________________________Relationship to patient: ________________________

Emer. Contact Phone: (__)_____-__________ Date of Birth: __________________

Revised: May21-BFC1

Insurance Information

Is this a work related injury?____Yes___No Date of injury_________Employer: ___________________________

Primary Insurance Information:

Insurance Company:___________________________Policy #_______________________Group#________________________

Policy Holder Name:_________________________Policy Holder DOB:__________________Gender:____Male____Female

SSN:____________________Relationship to Patient:_______________________Policy Holder Employer: _______________

Policy Holder Phone: __________________________________

Secondary Insurance Information:

Insurance Company:___________________________Policy #_______________________Group#________________________

Policy Holder Name:_________________________Policy Holder DOB:__________________Gender:____Male____Female

SSN:____________________Relationship to Patient:_______________________Policy Holder Employer: _______________

Policy Holder Phone: __________________________________

Family Size:_____________________________ Annual Household Income: _____________________

Sliding Fee Scale Discount Program

Bethel Family Clinic offers a sliding scale discount based on family size and income.
Please complete the sliding scale discount application form to determine your eligibility.

For more information and on the program, please ask the front desk for the application for the sliding discount fee scale application today.

I hereby decline to be considered for the Sliding Discount Fee Scale program at Bethel Family Clinic.

Signature: ____ **Date:** ________________________

I hereby authorize release of medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the Bethel Family Clinic. I understand that I am financially responsible for amounts not covered by my insurance or beneficiary status.

I hereby consent for the Bethel Family Clinic to administer treatments and to perform medical or procedures as necessary.

Signature:____**Date:** ______________________________________

(Patient, Parent or Guardian)

Privacy Practices Acknowledgement:
I have received the Notice of Privacy Practices and I have been provided an opportunity to review the Notice.

Print Name:____

Signature:____**Date:** ______________________________________

Revised: May21-BFC1

DENTAL HISTORY

Name________________________________ Nickname______________________________ Age_________
Referred by___________________________How would you rate the condition of your mouth? Excellent Good Fair Poor
Previous Dentist ________________________________How long have you been a patient?___________Months/Years
Date of most recent dental exam ______/______/______ Date of most recent x-rays ______/______/______
Date of most recent treatment (other than a cleaning) ______/______/______
I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? ____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] ________________________________
2. Have you had an unfavorable dental experience? ________________________________
3. Have you ever had complications from past dental treatment? ________________________________
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? ________________________________
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? ________________________________
6. Have you had any teeth removed or missing teeth that never developed? ________________________________

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? ________________________________
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? ________________________________
9. Have you ever noticed an unpleasant taste or odor in your mouth? ________________________________
10. Is there anyone with a history of periodontal disease in your family? ________________________________
11. Have you ever experienced gum recession? ________________________________
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? ____________
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? ________________________________

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years? ________________________________
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? ________________________________
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? ________________________________
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? ________________________________
18. Do you have grooves or notches on your teeth near the gum line? ________________________________
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? ________________________________
20. Do you frequently get food caught between any teeth? ________________________________

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) ________________________________
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? ________________________________
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? ____________
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? ________________________________
25. Are your teeth becoming more crooked, crowded, or overlapped? ________________________________
26. Are your teeth developing spaces or becoming more loose? ________________________________
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? ________________________________
28. Do you place your tongue between your teeth or close your teeth against your tongue? ________________________________
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ________________________________
30. Do you clench your teeth in the daytime or make them sore? ________________________________
31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? ______________
32. Do you wear or have you ever worn a bite appliance? ________________________________

SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change? ________________________________
34. Have you ever whitened (bleached) your teeth? ________________________________
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? ________________________________
36. Have you been disappointed with the appearance of previous dental work? ________________________________

Patient's Signature ____ Date________________________

Doctor's Signature ____ Date ________________________

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MEDICAL HISTORY

Patient Name ______________________________ Nickname ____________ Age ______
Name of Physician/and their specialty ______________________________
Most recent physical examination ____________________ Purpose ____________________
What is your estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD: YES NO

1. hospitalization for illness or injury ____________
2. an allergic reaction to ____________
   - aspirin, ibuprofen, acetaminophen, codeine
   - penicillin
   - erythromycin
   - tetracycline
   - sulfa
   - local anesthetic
   - fluoride
   - metals (nickel, gold, silver, __________)
   - latex
   - other ____________
3. heart problems, or cardiac stent within the last six months __
4. history of infective endocarditis ____________
5. artificial heart valve, repaired heart defect (PFO) ________
6. pacemaker or implantable defibrillator ____________
7. orthopedic implant (joint replacement) ____________
8. rheumatic or scarlet fever ____________
9. high or low blood pressure ____________
10. a stroke (taking blood thinners) ____________
11. anemia or other blood disorder ____________
12. prolonged bleeding due to a slight cut (INR > 3.5) ________
13. emphysema, shortness of breath, sarcoidosis __________
14. tuberculosis, measles, chicken pox ____________
15. asthma ____________
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)
17. kidney disease ____________
18. liver disease ____________
19. jaundice ____________
20. thyroid, parathyroid disease, or calcium deficiency ________
21. hormone deficiency ____________
22. high cholesterol or taking statin drugs ____________
23. diabetes (HbA1c = ______) ____________
24. stomach or duodenal ulcer ____________
25. digestive disorders (i.e. celiac disease, gastric reflux) ______
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) __

YES NO

27. arthritis ____________
28. autoimmune disease ____________
    (i.e. rheumatoid arthritis, lupus, scleroderma)
29. glaucoma ____________
30. contact lenses ____________
31. head or neck injuries ____________
32. epilepsy, convulsions (seizures) ____________
33. neurologic disorders (ADD/ADHD, prion disease) ______
34. viral infections and cold sores ____________
35. any lumps or swelling in the mouth ____________
36. hives, skin rash, hay fever ____________
37. STI / STD / HPV ____________
38. hepatitis (type ___) ____________
39. HIV / AIDS ____________
40. tumor, abnormal growth ____________
41. radiation therapy ____________
42. chemotherapy, immunosuppressive medication ______
43. emotional difficulties ____________
44. psychiatric treatment ____________
45. antidepressant medication ____________
46. alcohol / recreational drug use ____________

ARE YOU:

47. presently being treated for any other illness ________
48. aware of a change in your health in the last 24 hours
    (i.e. fever, chills, new cough, or diarrhea) ________
49. taking medication for weight management ________
50. taking dietary supplements ____________
51. often exhausted or fatigued ____________
52. experiencing frequent headaches ____________
53. a smoker, smoked previously or use smokeless tobacco _
54. considered a touchy / sensitive person ____________
55. often unhappy or depressed ____________
56. taking birth control pills ____________
57. currently pregnant ____________
58. prostate disorders ____________

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment.
(i.e. Botox, Collagen Injections)

____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature ______________________________ Date ____________
Doctor's Signature ______________________________ Date ____________

ASA _____ (1-6)

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