PUREVIEW | Dental Clinic

Legal Name	Last	First	Middle Initial	**Preferred Name**

Legal Sex (please check one) **O** Female **O** Male **While PureView recognizes a number of genders / sexes, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. If your preferred name and pronouns are different from these, please let us know.*	**Medical Provider**: Name: Phone:

Date of Birth Month Day Year / /	**Social Security #**	**Are You a Veteran? Yes No**

Your answers to the following questions will help us reach you quickly and discreetly with important information

Home Phone ( ) Okay to leave voice mail? Yes No	**Cell Phone** ( ) Okay to leave voice mail? Yes No	**Work Phone** ( ) Okay to leave voice mail? Yes No	**Best number to use:** **O** Home **O** Cell **O** Work

Address	**City**	**State**	**Zip**
Billing Address (if different from above)	**City**	**State**	**Zip**

Are You Homeless? Yes No (circle one) Shelter Transitional RV/Tent Doubling-Up Street Other_____

Email Address: **O** None **O** Choose not to share	**Do you want to sign up for the patient portal?** **O** Yes **O** No
Occupation/Employer:	**Are you covered under your employer's insurance?** **O** Yes **O** No

Emergency Contact Name:	**Phone #**	**Relationship to You**

If you are under the age of 18 we require that you provide parent/guardian contact information

Parent/Guardian Name	**Phone #**	**Relationship to You**

PureView Health Center will send certain correspondence such as results from labs and Diagnostic Imaging to your mailing address, **How would you like to receive this correspondence?** **O** Secure Email **O** Letter **O** Other

PureView Health Center is federally funded and, to be compliant with federal regulations, we are **required** to collect the following information from our patients. This will not effect the care you receive. Also, the personal information you provided prior to this section, is for PureView Health Center use only and will not be shared elsewhere.

What is your Annual Income? $_____ **O** No income **How many people, including you, does this income support?** _____	**Employment Status:** **O** Employed Full Time **O** Employed Part Time **O** Student Full Time **O** Student Part Time **O** Retired **O** Unemployed **O** Disabled **O** Other _____	**Racial Group(s)** (check all that apply) **O** Asian **O** Native Hawaiian **O** Other Pacific Islander **O** Black/African American **O** American Indian/Alaskan Native **O** White **O** Refuse to report	**Ethnicity:** **O** Hispanic/Latino/Latina **O** Not Hispanic/Latino/Latina **O** Refuse to report Country of Birth: **O** USA **O** Other _____
Preferred Language: **O** English **O** Español **O** Francais **O** Portugués **O** Other _____	**Marital Status:** **O** Married **O** Partnered **O** Single **O** Divorced **O** Widowed **O** Legally Separated	**Referral Source:** **O** Self **O** Friend/Family **O** Advertisement **O** Other _____	**Please Turn Over**

PureView Dental Center-Consent for Treatment

Date: _____ **Printed Name: _____**

I hereby give my consent and authorize PureView Dental Center to treat any dental health condition providing that the care provider has explained my condition.

I authorize the care provider to perform any additional or different treatment, which is thought necessary, should a condition be discovered during treatment that was not known previously.

I have carefully read and fully understand this Informed Consent Form and all of my questions have been adequately answered.

Treatment, Payment and Data Agreement

- I authorize examination and treatment for this and all following dental visits.
- I understand I am personally responsible for all charges and deductibles. Financial assistance is available for those who qualify.
- I am personally responsible for providing accurate and current insurance information.
- I authorize a photocopy of this statement to serve as the original and the use of this signature on all insurance submissions.
- I authorize release of all information necessary to secure payments of benefits and coordination of care.
- I understand that PureView Dental Center may use data developed for and/or provided by clients to determine general characteristics of the communities it serves and that none of this information will in any way identify individual clients.
- I authorize my insurance benefits be paid directly to the physician, I also authorize PureView or Insurance company to release any information required to process my claims.

I certify that the above information is true and correct. I have received a copy of PureView's Notice of Privacy Practices (HIPAA) and Patient Rights and Responsibilities.

General Information: Informed consent will be obtained from all patients accessing dental activities. Informed consent is not merely a signed document. It is an ongoing process that considers patient needs and preferences, compliance with law and regulation, and patient education.

The patient and/or family, as appropriate, are given information about:

- The patients' condition;
- Proposed treatments or procedures;
- Potential benefits and drawbacks of proposed treatments or procedures;
- Problems related to recuperation;
- Alternative treatment(s) or procedure(s);
- The physician or other practitioner primarily responsible for the patient's care;
- Others authorizing or performing procedures or treatments; and
- Any business relationships among individuals treating the patient, or between the organization and any other health facility.

Missed Appointment Policy Statement

- **A call less than 24 hours prior to an appointment will be considered a NO Show, unless an emergency or health issue is involved.**
- **A No Show appointment will result in all other pending appointments being cancelled.**
- **One No Show appointment will result in use of Pain Clinic Only.**
- **Arriving more than 10 minutes late for an appointment will result in a No Show. (This does not include 30 minute exam appointments for which we cannot accommodate latecomers.)**
- **By signing below, the patient is stating that they have read and understand the No-Show policy statement, Consent to Treatment and Payment and Data Agreement as above.**

Date_____ **Signature_____**