Park Place Dental Clinic
606. W. 29th St.
Norfolk, VA 23508
757-683-2692

Park Place Dental's Eligibility Checklist:

This clinic is for those with no kind of dental insurance.

Digital documentation will not be accepted and failure to bring all listed materials will result in not being qualified for services.

List of documents needed:

- Photo ID- Most recent picture ID (such as a Drivers License)
- Proof of Address- Utility Bill, Cell phone Bill, current lease (no month to month), rent statement postmarked within 60 days- No personal or Junk Mail will be accepted. If currently residing at a shelter, we need a letter from the shelter stating you're a resident that is dated within the current 30 day period.
- Current List of Medications
- $25 Cash or Money Order (This will cover your first appointment then all appointments after will be $25 each)
- Proof of income; Please see list below to determine what documents you will need. **We need all these documents for yourself, your spouse, dependents and/or anyone else you claim on your taxes**

Are you or any member of your household currently **employed**?	☐ Yes ☐ No	**Current 30 day period** of recent pay stubs or a signed letter from employer on company letterhead with rate of pay and number of hours worked weekly (before taxes) for each working member(If your stub shows **Married** you must provide spouse income)
Are you or any member of your household **self-employed**?	☐ Yes ☐ No	Complete tax forms including business taxes from the most recent filing year and latest quarterly filing **AND** 60 days worth of bank statements, receipts, invoices **AND** a *W-6 from the Virginia Employment Commission*
Are you or any member of your household **not currently working**?	☐ Yes ☐ No	If you or anyone else in your household are currently not working, then they must bring in a **W-6** from Virginia Employment Commission. They are located at *861 Glen Rock Rd, Norfolk, VA*. **Keep in mind we may need this form in addition to other income information to verify you are not working outside of receiving your benefits.**
Are you or any member of your household receiving **Social Security** or **Supplement Security Income** and/or **Disability**?	☐ Yes ☐ No	Current year SS Benefit award letter for each member in household; You can contact Social Security at 1-800-772-1213 or visit your local office to obtain a copy of your most recent award letter **AND** a *W-6 from the Virginia Employment Commission.* If someone else is your payee, then we need proof of their income as well.
Do you or any member in your household receive **Veteran Benefits**?	☐ Yes ☐ No	Current recent benefit award letter showing monthly amount. **AND** a *W-6 from the Virginia Employment Commission*
Do you or any member of your household receive a **Pension or Retirement**?	☐ Yes ☐ No	Current year Pension/Retirement Statement showing your monthly amount **AND** a *W-6 from the Virginia Employment Commission*
Do you or any member of your household receive **Unemployment**?	☐ Yes ☐ No	Current unemployment award letter indicating amount and time period covered or 60 days of most recent unemployment checks
Do you or any member in your household receive **Alimony or Child Support**?	☐ Yes ☐ No	Most recent court award letter indicating amount and time period covered and/or Child Support Enforcement Agency letter and/or letter from your attorney stating amount and time period covered
Do you or any member of your household receive **Worker's Compensation**?	☐ Yes ☐ No	Most recent letter or benefits statement indicating amount and time period covered and/or 60 days worth of check stubs
Do you or any member of your household receive **SNAP** benefit? (Food Stamps)	☐ Yes ☐ No	Most recent SNAP letter- *Reminder, the income your SNAP letter shows must match with any other income reported*
Do you or any member of your household receive **TANF or TANF Transitional Assistance**?	☐ Yes ☐ No	Most recent TANF letter or TANF Transitional Letter

****Once you complete your application, your paperwork is good for 1 year. You will be required to re-certify each following year to maintain eligibility. Appointments are set up for a future date and are NOT same day services****

We are not associated with Social Services or with any City Service and as such we have our own requirements to be seen.

Park Place Health & Dental Clinic- Health History

Name (first middle last)	Date of Last Treatment	Date of Birth
Emergency Contact Name:	Relationship to patient	Emergency Contact Phone #

Are you now under the care of a physician? ☐ **Yes** ☐ **No**

Are you taking **any** drug(s) or medicine(s), including over-the-counter? ☐ **Yes** ☐ **No**
If yes, please list the medicine(s) : _____

_____

Are you **allergic** or have you had **a reaction** to any of the following? ☐ **NO** ☐ **Yes (Please check those that apply)**:

☐ **Local anesthetics**
☐ **Sedatives**
☐ **Barbiturates**
☐ **Penicillin or other Antibiotics**
☐ **Sulfa or Sulfa Drugs**
☐ **Aspirin**
☐ **Codeine**
☐ **Iodine**
☐ **Latex**

Place Medical Alert Sticker Here

Other please list_____

Are you pregnant? ☐ **Yes** ☐ **No**

Have you ever tested Positive for COVID-19? ☐ **Yes** ☐ **No**
If Yes, Provide Date Frame: _____

Do you **have** or **have you had any** of the following diseases or problems? **Please mark an "X' by your choice.**
All Boxes MUST be Checked

	Yes	No	Not Sure
Epilepsy or seizures	☐	☐	☐
Fainting or dizziness	☐	☐	☐
Nervousness	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Cold sores (Herpes)	☐	☐	☐
Emphysema	☐	☐	☐
Tuberculosis	☐	☐	☐
Asthma	☐	☐	☐
Hay Fever	☐	☐	☐
Sinus Problems	☐	☐	☐
Anemia	☐	☐	☐
Sickle Cell Disease	☐	☐	☐
Diabetes	☐	☐	☐
Bruise or Bleed easily	☐	☐	☐
Transplants	☐	☐	☐
HIV Positive/AIDS	☐	☐	☐

	Yes	No	Not Sure
Heart Surgery	☐	☐	☐
Heart Problems or Angina	☐	☐	☐
Hypertension (High Blood Pressure)	☐	☐	☐
Rheumatic Fever	☐	☐	☐
Heart Murmur	☐	☐	☐
Mitral Valve Prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Blood transfusion	☐	☐	☐
Liver Disease	☐	☐	☐
Hepatitis – Type ___	☐	☐	☐
Ulcers	☐	☐	☐
Kidney Problems	☐	☐	☐
Venereal disease	☐	☐	☐
*Joint Replacement*_____	☐	☐	☐
Dialysis	☐	☐	☐
Do you or have you used tobacco Products? How long?_____ Date stopped _____	☐	☐	☐

(*Italics=Medical Alert and Pre-medicate*) (**Bold** = Medical Alert)

Do you have any disease, condition or health problem not listed above?
☐ **Yes** ☐ **No**
If yes, please explain: _____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the Dental Staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

Signature	**Date**	**Office Use Only**
Renewal Signature- Sign After Yearly Review	***Renewal Date***	***Office Use Only***

Park Place Health and Dental Clinic

Please Print

1. Name (First, MI, Last)	2. Date of Birth	3. Social Security #	4. Do you have Dental Insurance? Yes □ No □
5. Mailing Address	6. Zip Code	7. Home Phone #	8. Do you have Medical insurance? Yes □ No □ If Yes, check one: Medicare □ Medicaid □ Private □ Who is your plan provider?
9. Employer/Company Name and Phone	10. Full Time □ Part Time □	11. Work Phone #	12. Number of people in the household._____ Single Female Head of Household? Yes □ No □

13. Other Sources of Income	14.(Staff to fill in this block)	15. Yearly Total (Staff to fill in this block)	16. Is Patient a U.S Veteran? Yes □ No □ Which Branch?
Social Security □ Disability □ Retired □ Other □	Weekly $ _____ Bi-weekly $ _____ Monthly $ _____		

17. Race: Caucasian □ African American □ African American & Caucasian □ Hispanic □ Asian □ Asian & Caucasian □ Asian / Pacific Islander □ American Indian / Alaskan Native □ American Indian / Alaskan Native & Black □ Middle Eastern □ American Indian / Alaskan Native & Caucasian □ Native Hawaiian / Other Pacific Islander □ Other Multi – Racial □

18. Who referred you to this clinic? Self □ Friends/Family □ Agency □ Hospital/Doctor □	19. What is your highest level of Education?	20. Marital Status: Single □ Married □ Divorced □ Co-habitation □ Widowed □	21. Verified by (Staff to fill in this block)

Dental Records

I authorize the Park Place Health and Dental Clinic to dispose of my individual dental records ten (10) years after the last date of service. If there is an action pending against a record no disposition will be made. Once an agreement has been made, the record will be maintained for two (2) years or the normal ten (10) year retention period which ever is longer.

Notice of Statutory Consent

As a health care provider, we are required by 32.1-45.1 code of Virginia to give you the following notice.
If one of the doctors, staff, or any person volunteering for the Park Place Health and Dental Clinic is directly exposed to patients body fluids in a manner that may, according to the current guidelines of The Center for Disease Control, transmit Immunodeficiency Virus (the AIDS virus) or Hepatitis B or C virus, the patients whose body fluids were involved in the exposure shall be deemed to have consented to testing for infection with the AIDS virus or Hepatitis B or C Viruses. The results of this test may be released to the person who was exposed to the patient's body fluid. In an emergency situation, such notice is not required by law.

This consent remains in effect as long as I receive care from the Park Place Health and Dental Clinic.
The undersigned represents that he or she has read and fully understands the meaning of this notice.

Treatment Authorization

I authorize treatment by the dentist, volunteer and/or staff at the Park Place Health and Dental Clinic. I understand and agree that all health care professionals rendering services at the Park Place Health and Dental Clinic are exempt from liability for any torts or personal injury that I may suffer. No person who is legally licensed and renders health care services within the limits of his/her license voluntarily and without compensation at the Park Place Dental Clinic Health, where no charges are made for any health care services, act or omission was the result of gross negligence or willful misconduct.

Patient Agreement

During my visit no one can accompany me in the treatment room unless provided proof of being a caregiver or POA.
I also understand that often times, services are rendered by Senior Dental Students under the supervision of a Licensed Dentist who qualifies to oversee the work of said students. More so, our clinic does reserve the right to refuse services base off of demeanor or behaviors at any time.

Privacy & Documentation

The Park Place Health and Dental Clinic is funded in part by a CDBG grant. All patient eligibility forms are subject to audit by the City of Norfolk (hence why documentation is important to qualify for services). It is understood that all information is privileged and will be used to verify compliance with the terms of this grant.

Signature	Date	Office Use Only
Renewal Signature—Sign After Yearly Review	***Renewal Date***	**Office Use Only**

Park Place Dental Clinic's Patient's Consent to Treatment

I hereby authorize the Dentist and any other Volunteers of the Park Place Health & Dental Clinic at Park Place Multi-Service Center and such assistants as may be selected by any of them, to treat the conditions described below:

The procedure(s) necessary to treat the condition(s) have been explained to me and I understand the nature of the procedure and consent to understanding the following:

- I have been informed of possible alternative methods of treatment ***(if any)***.
- I have further understood that this is an elective procedure and other forms of treatment or no treatment at all are choices that I have, and that the recommended treatment provided by my Dentist, will provide the best relationship between teeth, jaws, muscles, and the tempromandibular (jaw) joint that is possible at this time.
- The doctor has explained to me that there are certain inherent and potential risks in any treatment plan or procedure, and that this specific instance such operative risks include, but are not limited to, the following:
    - Postoperative discomfort and swelling that may necessitate several days of home recuperation.
    - Heavy bleeding that may be prolonged.
    - Injury to adjacent teeth and fillings.
    - Postoperative infection requiring additional treatment.
    - Stretching of the corners of the mouth with resultant cracking and bruising.
    - Restricted mouth opening for several days or weeks.
    - Decision to leave a small piece of root in the jaw when its removal would require extensive surgery.
    - Breakage of the jaw. *(Very Rare Cases)*
    - Injury to the nerve underlying the teeth resulting in numbness or tingling of the chin, lip, cheek, gums and /or tongue on the operated side; this may persist for several weeks, months, or in remote instances, permanently.
    - Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery.
    - Cardiac arrest
    - Any other unforeseen complications due to dental procedure

- It has been explained to me that, during the course of the procedure(s) unforeseen conditions may be revealed that necessitates an extension of the original procedures or different procedures than those set forth in paragraph 2 above. I, therefore authorize and request that the Dentist(s) described in paragraph 1 above perform such procedures as are necessary and desirable in the exercise of professional judgement.

- The authority I grant by signing this waiver should extend to the treatment of all other conditions that require additional treatment and are not known at the time the original procedure is commenced.

- I consent to the administration of anesthesia ,to include local general anesthesia (such as topical or Lidocaine) in connection with the procedure (s) referred to above, and administered by said Dentist (s), and to the use of such anesthetics as may be deemed advisable unless specifically stated previously of any allergies to such

- In any cases where a prescription (s) is prescribed by Dentist, I understand that it may cause drowsiness and lack of awareness and coordination and said prescription (s) can increase those affects while under alcohol or drug influence. Understanding and Usage of prescription (s) will be explained prior to you leaving our office as well.

- It is always recommended that an additional adult accompany you to help you home after said treatment (**additional adult must wait outside the building until patient exits the building**), and that any numbness or drowsiness affects may take a few hours to loss it's effects

- Patient is reminded that the clinic is exempt from liability to any torts or personal injury suffered while being treated under Virginia Risk Management

It has been explained to me, and I understand that a perfect result is not guaranteed or warranted and cannot be guaranteed or warranted.

I certify that I read and write English and read and fully understand this consent for surgery.

****Please ask the doctor if you have any questions concerning this consent form.**

Signature	**Date**	**Office Use Only**
Renewal Signature- Sign After Yearly Review	***Renewal Date***	***Office Use Only***

Park Place Dental
General Dental Treatment Consent Form for COVID-19

I. I knowingly and willingly consent to treat at Park Place Dental Clinic (Located at 606. W. 29th St. Norfolk, VA) with any designated staff members and/or volunteers during the COVID-19 pandemic

II. I understand that Park Place Dental Clinic and any designated staff members and/or volunteers are following proper CDC, VDA, & ADA protocols for treatment and infection control

III. I am aware of being a possible carrier or infected and I confirm that I have not tested positive for COVID-19 in the last 30 days and that I am not presenting with any of the following symptoms associated with COVID-19
   a. A Fever of 100.5 degree Fahrenheit or higher
   b. Shortness/difficulty breathing
   c. Dry cough
   d. Runny nose
   e. Sore throat
   f. Diminished sense of taste

IV. Contact with infected: I confirm I have not knowingly been in close contact defined as 6 ft or less for a duration of 15 minutes or more with someone who has tested positive for COVID-19 in the last 30 days

V. Public travel: I confirm that I have not traveled outside of the United States within the last 30 days.

VI. I understand that due to visits of other dental patients, the characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus simply by being in the dental office

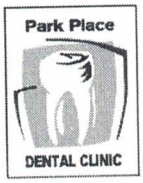
VII. I understand the CDC recommends social distancing of at least 6 ft, however, that is not possible with dentistry

VIII. I understand that seeking dental treatment during COVID-19 requires that dental professionals take extra precautions for the safety of patients and dental staff and volunteers. **If I contract COVID-19 at any point before, during, or after my dental appointment, I understand that I will not be able to hold Park Place Dental or the City of Norfolk liable for any costs or issues associated with contracting COVID-19**

Signing this consent form acknowledges my understanding all the above and that I do voluntarily assume any and all reasonable medical/dental risks involved. I also acknowledge I have had time to ask any questions I may have

Patient Name (Printed) Signature of Patient Date

Witness to signature Date



48 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care and provider time goes unused. Therefore, Park Place Dental Clinic reserves the right to require the patient to pre-pay our fee of $25 in order to receive a new appointment for all missed appointments ("no shows") and appointments which, absent a compelling reason and provided proof, are not cancelled with a 48-hour advance notice.

Patients who fail to keep an appointment or who cancel or reschedule an appointment less than 48 hours prior to their appointment will be required to prepay our fee of $25 in order to schedule another office visit. No appointments or other clinic services will be available until the fee has been paid.

If you are more than 15 minutes late past your appointment time, you will automatically forfeit your appointment and lose your appointment fee.

In addition: With concerns relating to COVID-19, we have adjusted our "no show and cancellation policy" to reflect additional changes. If any point before your appointment you feel sick and are concerned with having COVID, you may call to cancel your appointment, HOWEVE,R you will only be re-scheduled with the same $25 fee when you provide the clinic proof of a NEGATIVE COVID-19 result within 30 days of cancellation. Failure to provide proof means you will forfeit your fee and still be required to provide a negative test result before making a new appointment. If proper protocol is followed you will have 6 months to make a new appointment with the same fee.

Four (4) "no shows" in any 12 month period will result in termination from services.

If staff has approved your cancellation within the 48 hours, you then will have either 30 days from your original appointment date to request a refund or 6 months from your original appointment date to transfer your payment to a rescheduled appointment.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients with the help of our wonderful volunteers.

By signing below, you acknowledge that you have received this notice and understand this policy.

Patient Name Printed _____ Patient Signature _____ Date _____

Witness Signature _____ Date _____