Park Place Health and Dental Clinic

Please Print

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

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

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, and 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 my minor children will not be allowed into the treatment room. I must provide my own child care. I am also aware that if I arrive more than 15 minutes past my appointment time I will not be seen or rescheduled and that my $25 is forfeited.

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**