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 NEW PATIENT CHECKLIST FORM

 DENTAL ONLY

The **Mel Leaman Free Clinic** can provide *FREE*, *Quality*,

*Dental services* to those who meet the following eligibility criteria:

\_ \_\_\_\_\_ Must be a **Smyth**, **Grayson**, or **Washington** Counties Resident

\_ \_\_\_\_\_ **Uninsured** – *cannot* have Dental Insurance

\_\_\_\_\_ Are **18 Years** of age *or older*

\_ \_\_\_\_\_ Have a **Photo ID**

\_\_\_\_\_ Meet the **Income Guidelines** (*as shown on right*) except for Medicaid recipients

 P**roof of household income** This May Include:

1. *Most Current* **Tax Return**, **W2**, *or* **1099** (*acceptable for 1 year*)

2. *Most Current* **Public Assistance Benefit** letter (*acceptable for provided dates only*)

3. *30 Days*of **Paystubs** (*acceptable for one month only*)

4. Current **Unemployment Statement** (*acceptable for provided dates only*)

 **Family Size Monthly Yearly**



$3,220 $38,640

$4,355 $52,260

$5,490 $65,880

$6,625 $79,500

$7,760 $93,120

$8,895 $106,740

◆ If you meet the above eligibility criteria, please complete a New Patient Application◆

Call if you have any questions, or submit the application by mail, fax, email or in person to:

601 Radio Hill Road • Marion, VA 24354

*Tel*: (276) 781-2090 • *Fax*: (276) 781-0866

<http://melleamanfreeclinic.org>

info@melleamanfreeclinic.org

The Mel Leaman Free Clinic is open: **\***Hours are subject to change

Monday-Friday: **9:00am - 5:00pm\* \***Patients will be seen by ***appointment only***

*Closed Every Day* for Lunch from ***12:30pm-1:30pm***

A

ll services at **MLFC** are provided **free of charge**.

*However, patients referred to other offices may incur charges for those services.*

*We will do our very best to assist with financial assistance applications when possible.*

New *and* Established patients *must provide* a ***Photo ID*** and ***Proof of Income*** (*to be updated yearly*)

Without this information your application cannot be screened and appointments cannot be made

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Dental Services

**‣Name:**  **‣Preferred Name:**

**‣DOB:**   **‣ SSN:**  **‣Gender:** □ *Female* □ *Male*

**‣Medicaid, Medicare and/or Private Medical Insurance: Y** *or* **N Company:**

**‣Address *(****Physical****)*:**  **City/State/Zip:**

**‣Address *(****Mailing****)*:** **City/State/Zip:**

**‣Home Phone #**  **‣** *Can we*Leave *Voicemail Messages?* **Y** *or* **N**

**‣Cell Phone #**  **‣** *Can we Text Appointment Reminders?* **Y** *or* **N**

**‣** **Language:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_ **‣** **Race/Ethnicity:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ‣ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**⬩** Please list an ***EMERGENCY CONTACT*** person below **⬩**

**Name:** **Phone:** **Relationship:**

**ALLERGIES**

*(Have you ever had any allergic reactions to the following? Please circle* ***Y*** *or* ***N*** *and elaborate if applicable)*

1. Anesthetics (*Local*)? **Y** *or* **N ‣** Reaction: **\_\_\_\_\_\_\_\_\_\_\_\_‣** Severity? □ *Mild* □ *Moderate* □ *Severe*
2. Aspirin? **Y** *or* **N ‣** Reaction: **\_\_\_\_\_\_\_\_\_\_\_\_‣** Severity? □ *Mild* □ *Moderate* □ *Severe*
3. Iodine *or* Latex? **Y** *or* **N ‣** Reaction: **\_\_\_\_\_\_\_\_\_\_\_\_‣** Severity? □ *Mild* □ *Moderate* □ *Severe*
4. Sulfa Drugs? **Y** *or* **N ‣** Reaction: **\_\_\_\_\_\_\_\_\_\_\_\_‣** Severity? □ *Mild* □ *Moderate* □ *Severe*
5. Penicillin? **Y** *or* **N ‣** Reaction: **\_\_\_\_\_\_\_\_\_\_\_\_‣** Severity? □ *Mild* □ *Moderate* □ *Severe*
6. Unlisted Antibiotics? **Y** *or* **N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_‣** Reaction: **\_\_\_\_\_\_\_\_\_\_\_\_‣** Severity? □ *Mild* □ *Moderate* □ *Severe*
7. Unlisted Allergies? **Y** *or* **N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_‣** Reaction: **\_\_\_\_\_\_\_\_\_\_\_\_‣** Severity? □ *Mild* □ *Moderate* □ *Severe*

**PROBLEMS**

**Describe any current medical treat, impending surgery, or other treatment that may possibly affect your dental treatment.**

**Do you take antibiotic premedication for you dental visits? If yes, please explain.**

**What dental issues are you having?**

**MEDICATIONS**

|  |  |  |  |
| --- | --- | --- | --- |
| NAME OF MEDICATION |  DOSE | HOW OFTEN |  CURRENTLY TAKING (Within Last 3 Months) |
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Please list **ALL MEDICATIONS** (*Prescription*, *Over the Counter*, *Vitamins*/*Supplements*)

**SOCIAL HISTORY**

**‣***Smoking*: **Y** *or* **N** **‣** *Packs Per Day*? **‣** *Smoked Since Age*: **‣***Vaping* **Y***or* **N**

**‣** *Alcohol Intake*: □ **None** □ **Occasional** □ **Moderate** □ **Heavy**

**‣** *Caffeine Intake*: □ **None** □ **Occasional** □ **Moderate** □ **Heavy**

**‣** *Chew/Dip*: **Y** *or* **N** **‣** *Cans Per Day*?  **‣***Chew/Dip since age:*

**‣** *Past/Present Use of Marijuana*? **Y** *or* **N**

**‣** *Past/Present Use of Cocaine, Meth, IV Drugs, Etc…*? **Y** *or* **N**

**‣ How did you hear about us?** □ Community Event □ News Article □ Radio □ Social Media/Online
 □ Billboard □ Word-of-Mouth □ Written Material □ One of our patients (name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current/Past Medical History**

|  |
| --- |
| **Circle all that apply:** |
| ADD / ADHD | Diabetes | MRSA |
| Abuse / Domestic Violence | Difficulty Swallowing | Mental Illness |
| Alcohol Abuse / Overuse | Diverticulitis | Muscle, Joint, Bone Problems |
| Allergies / Hay Fever | Ear or Hearing Problems | Neck Injury |
| Anemia | Eating Disorders | Neurological Disorder |
| Aneurysm | Eczema | Neuropathy |
| Anxiety Disorder | Endometriosis | Obesity |
| Arrhythmia | Fibromyalgia | Osteoporosis / Osteopenia |
| Arthritis | Gastrointestinal Disease | Peripheral Vascular Disease |
| Asthma | Gout | Pre-Eclampsia |
| Autoimmune Disease | Head Trauma / Injury | Prostate Problems |
| Back Pain | Headaches | Pulmonary Embolism |
| Birth defects/ Inherited disease | Heart Attack | Reflux / GERD |
| Bladder / Kidney Problems | Heart Disease | Rheumatoid Arthritis |
| Bleeding Disorder | Heart Problems | Seizures / Epilepsy |
| Blood Clots | Hepatitis A, B, C | Skin Problems |
| Blood Disease | Hernia | Sleep Apnea |
| Blood Transfusion | High Cholesterol | Stroke |
| COPD | Hypertension | Thrombophilia |
| Cancer | Hyperthyroidism | Tuberculosis |
| Carpal Tunnel | Hypothyroidism | Vascular Disease |
| Chicken Pox | Kidney Disease | Vertigo |
| Chronic Ear Infection | Kidney Stones | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Congestive Heart Failure | Leg or Foot Ulcers | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Constipation | Liver Disease | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Depression | Lung Disease | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**DENTAL SERVICES** *–* **HIPPA/CONSENT FORM**

*PLEASE READ AND INITIAL EACH LINE:*

* I hereby consent to have my blood tested, *if necessary*, to determine whether I have the antibodies to *HIV/AIDS* present in my blood. I understand that the test is performed with minimal risk by withdrawing blood and having that blood tested by an outside lab. There is no alternative test for that purpose. **\_\_\_\_\_\_\_\_\_\_\_**
* I understand that my medical record maintained by my provider will contain the order for the test and a copy of the results. I understand that if my blood contains the antibodies of *HIV* my results *will be reported* to the **Virginia Department of Health** as *required* by law. In addition, any health care providers directly responsible for my treatment/care will be informed of a positive result so they have the knowledge to give me the best possible care.
* I understand that I have an opportunity for *face-to-face disclosure* of these results as well as *counseling*. I understand that it is necessary for me to return to discuss the meaning of these results with my health care team. I further understand that any information regarding my test results shall be confidential and *will not be disclosed* except in accordance of the law.
* I hereby give permission for treatment by the medical/dental staff at the **Mel Leaman Free Clinic *(MLFC)***. Including any necessary testing *(labs/procedures/x-rays/referrals)* held outside of the MLFC. As such, the MLFC cannot be responsible for *any payments* incurred for necessary *testing/treatments* held outside of the office, ***I would be responsible for any/all payments.*** **\_\_\_\_\_\_\_\_\_\_**
* I understand that my medical records are private. It is a violation of ***HIPAA*** laws for the MLFC to disclose my information to anyone without my written consent. **\_\_\_\_\_\_\_\_\_\_\_**
* I acknowledge that I am subject to seeing different providers at any given time. I understand that each provider is qualified to deliver quality care, and, that **they are volunteers** and are here on *their own time*. **\_\_\_\_\_\_\_\_\_\_\_**
* I further understand that it is my responsibility to provide the clinic with *any updates/changes* of *my* (*or* my *Emergency Contact’s*) ***address***, and ***phone number***; knowing that the clinic may need to contact me to provide care. **\_\_\_\_\_\_\_\_\_\_\_**

**By signing this agreement, I acknowledge that I have read and understand all guidelines made by the Mel Leaman Free Clinic; if I *do not comply* with *any item* of this agreement, I may become *ineligible* to receive services.**

***SIGNED:* *DATE:***

***STAFF:* *DATE:***

**Mel Leaman Free Clinic Policies**

**PRESCRIPTIONS**

* The Mel Leaman Free Clinic will ***NOT prescribe any:*** Controlled Substances, Narcotics, Sleeping Pills, Etc. *(e.g. Xanax, Ativan, Lortab, Codeine, Klonopin, Neurontin…)*.

 **APPLICATIONS/FORMS**

* The Mel Leaman Free Clinic does not personally endorse, or fill out ***any paperwork*** for patients regarding Unemployment, SSI/Disability Applications, Claims, Inquiries, or Similar Forms.

 **STAFF TREATMENT**

* As a patient of the Mel Leaman Free Clinic, I will treat *all* the **Volunteers**, **Staff** and **Providers** with ***respect***. I will **NOT** attempt to call or contact anyone at their home, secondary work place, or *anywhere outside the clinic*. Violations of this policy will result in complete dismissal from the MLFC.

 **NO SHOW/CANCELLATION/RESCHEDULE/TARDY**

* We ask that all patients give a **24-HOUR** notice to the office if you are unable to keep a scheduled appointment. Appointments are in high demand and your early cancellation will give another patient the opportunity to be treated.
* After **ONE (1)** *no-shows*, **TWO (2)** late arrival (15 minutes) or improper *cancellation* you will be ineligible for dental services for six months.

**Please sign below as confirmation that you have read, understand, and will follow**

**The Mel Leaman Free Clinic’s policies**

***SIGNED:* *DATE:***

***STAFF:* *DATE:***