DENTAL ONLY

Completed application
Household Income
Referral from PCP
Copy of Insurance Card

Uninsured/Insured
Revised 1/13/21

Ebenezer Medical Outreach, Inc. Dental Clinic

Welcome to Ebenezer Medical Outreach, Inc. (EMO). We appreciate your choosing us for your health care needs, and we are committed to doing our best for you. Our goal is to provide you with high-quality, affordable health care.

Thank you for choosing us for your medical care.

PATIENT INFORMATION **Date**_____

Patient Name _____
LAST FIRST MIDDLE MAIDEN

Date of Birth _____ Sex: □ M □ F Marital Status: □ Single □ Married □ Divorced □ Widowed

Social Security Number _____ Email Address _____

Preferred Language:

□ Arabic	□ English	□ Hindi	□ Spanish
□ Chinese	□ German	□ Russian	□ Other: _____

Race:

□ African American	□ Asian	□ Hispanic/Latino	□ Pacific Islander
□ Alaska Native	□ Caucasian/White	□ Native American	□ Declined

Ethnicity:

□ Hispanic/Latino □ Non-Hispanic/Latino □ Declined Are you a US Citizen? □ Yes or □ No

Patient Address _____
STREET COUNTY

_____
CITY STATE ZIP

Driver's License Number _____
STATE

Home Phone _____ Work Phone _____ Mobile Phone _____

Employer Name _____

Employer Address _____
STREET

_____
CITY STATE ZIP

Are you a current patient of Ebenezer Medical Outreach? □ Yes or □ No
Primary Care Provider _____ Name of Referring Provider_____

If under 18, who is parent or legal guardian?

Guardian Name _____ Date of Birth _____

Responsible Party (Person who will be responsible for any amount not covered by insurance) _____
Relationship to Patient _____

Social Security Number _____ Date of Birth _____

Address _____
STREET

_____
CITY STATE ZIP

Home Phone _____ Work Phone _____ Mobile Phone _____

Employer Name _____

Employer Address _____
STREET

_____
CITY STATE ZIP

Spouse's Name/Other Parent if under 18 _____

Employer Name_____ Work Phone _____

In case of an emergency, notify (friend or relative not in your home):
Name _____ Phone _____

Relationship to Patient _____

INSURANCE INFORMATION

Primary Dental Insurance _____ Phone _____

Policy Holder Name _____ Date of Birth _____

Address _____
STREET

_____
CITY STATE ZIP

ID Number _____ Group Number _____
Plan Number _____ Effective Date _____ Expiration Date _____

Primary Medical Insurance _____ Phone _____

Policy Holder Name _____ Date of Birth _____

Address _____
STREET

_____
CITY STATE ZIP

ID Number _____ Group Number _____
Plan Number _____ Effective Date _____ Expiration Date _____

Other Medical/Dental Insurance (Worker's Comp., Medicare Supplement, Etc.)

Medical/Dental Insurance _____ Phone _____

Policy Holder Name _____ Date of Birth _____

Address _____
STREET

_____
CITY STATE ZIP

ID Number _____ Group Number _____
Plan Number _____ Effective Date _____ Expiration Date _____

PATIENT'S AGREEMENT

Please Read Carefully

I consent to care and treatment

I consent to examination, treatment and testing as advised by the dental providers of Ebenezer Medical Outreach, Inc.(EMOI) Dental Clinic. I give permission for health care professionals in training to observe and participate in my care and treatment under the supervision of licensed health care providers. In addition, I consent to the use or disclosure of my protected health information by EMOI Dental Clinic to diagnose and treat me, to obtain payment for my bills and to conduct its health care operations and business.

I acknowledge that I have received or was offered a copy of EMOI Notice of Privacy Practices which tells how my health information may be used and shared. I understand that EMOI Dental Clinic reserves the right to revise the notice at any time, and that I can always get the current copy by asking for it.

I agree that payments can be made to University Physicians and Surgeons, Inc.
EMOI has contracted with University Physicians and Surgeons, Inc, (UP&S) DBA Marshall Health. I allow University Physicians and Surgeons, Inc, (UP&S) to directly bill and collect payment from Medicaid. I assign my right to receive payment of any insurance to UP&S.

I agree to have EMOI Dental Clinic complete any enrollment process, which includes providing financial information, for available patient assistance programs sponsored by pharmaceutical companies to secure my prescribed medication.

If you have any questions about this document, please ask someone at the front desk for assistance.
I have read this form and I fully understand what I am agreeing to. *(The patient or another responsible party on behalf of the patient must sign this Agreement. Upon signing, the responsible party assumes all liability for the consents, authorizations and financial responsibility discussed above.)*

_____ _____
Date Signature of Patient or Legal Representative

STATEMENT OF PATIENT'S LEGAL REPRESENTATIVE OR AGENT

I give the consents and authorizations made above on behalf of the patient and I have the authority to do so. The patient did not sign because he or she is (check one):

_____ Mentally or physically unable to understand or sign
_____ Other (describe): _____

I am authorized to sign for the patient because: (*for example, having medical power or attorney)* _____

Medical & Dental History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? O Yes O No If yes
Have you ever been hospitalized or had a major operation? O Yes O No If yes
Have you ever had a serious head or neck injury? O Yes O No If yes
Are you taking any medications, pills or drugs? O Yes O No If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? O Yes O No
If yes

Are you on a special diet? O Yes O No

Do you use tobacco? O Yes O No **If yes, which type and how much per day**

Do you use controlled substances? O Yes O No **If yes, type and how often**

Women: Are you,
O Pregnant/trying to get pregnant O Nursing O Taking oral contraceptives

Are you allergic to any of the following?
O Aspirin O Metal O Penicillin O Latex O Codeine O Sulfa Drugs O Acrylic
O Local Anesthetics O Other **If yes**

Do you have or have you had any of the following?

AIDS/HIV Positive	O Yes O No	Cortisone Medicine	O Yes O No	Hemophilia	O Yes O No	Radiation Treatments	O Yes O No
Alzheimer's Disease	O Yes O No	Diabetes	O Yes O No	Hepatitis A	O Yes O No	Recent Weight Loss	O Yes O No
Anaphylaxis	O Yes O No	Drug Addiction	O Yes O No	Hepatitis B or C	O Yes O No	Renal Dialysis	O Yes O No
Anemia	O Yes O No	Easily Winded	O Yes O No	Herpes	O Yes O No	Rheumatic Fever	O Yes O No
Angina	O Yes O No	Emphysema	O Yes O No	High Blood Pressure	O Yes O No	Rheumatism	O Yes O No
Arthritis/Gout	O Yes O No	Epilepsy or Seizures	O Yes O No	High Cholesterol	O Yes O No	Scarlet Fever	O Yes O No
Artificial Heart Valve	O Yes O No	Excessive Bleeding	O Yes O No	Hives or Rash	O Yes O No	Shingles	O Yes O No
Artificial Joint	O Yes O No	Excessive Thirst	O Yes O No	Hypoglycemia	O Yes O No	Sickle Cell Disease	O Yes O No
Asthma	O Yes O No	Fainting Spells/Dizziness	O Yes O No	Irregular Heartbeat	O Yes O No	Sinus Trouble	O Yes O No
Blood Disease	O Yes O No	Frequent Cough	O Yes O No	Kidney Problems	O Yes O No	Spina Bifida	O Yes O No
Blood Transfusion	O Yes O No	Frequent Diarrhea	O Yes O No	Leukemia	O Yes O No	Stomach/Intestinal Disease	O Yes O No
Breathing Problems	O Yes O No	Frequent Headaches	O Yes O No	Liver Disease	O Yes O No	Stroke	O Yes O No
Bruise Easily	O Yes O No	Genital Herpes	O Yes O No	Low Blood Pressure	O Yes O No	Swelling of Limbs	O Yes O No
Cancer	O Yes O No	Glaucoma	O Yes O No	Lung Disease	O Yes O No	Thyroid Disease	O Yes O No
Chemotherapy	O Yes O No	Hay Fever	O Yes O No	Mitral Valve Prolapse	O Yes O No	Tonsillitis	O Yes O No
Chest Pains	O Yes O No	Heart Attack/Failure	O Yes O No	Osteoporosis	O Yes O No	Tuberculosis	O Yes O No
Cold Sores/Fever Blisters	O Yes O No	Heart Murmur	O Yes O No	Pain in Jaw Joints	O Yes O No	Tumors or Growths	O Yes O No
Congenital Heart Disorder	O Yes O No	Heart Pacemaker	O Yes O No	Parathyroid Disease	O Yes O No	Ulcers	O Yes O No
Convulsions	O Yes O No	Heart Trouble/Disease	O Yes O No	Psychiatric Care	O Yes O No	Venereal Disease	O Yes O No
						Yellow Jaundice	O Yes O No

Have you ever had any serious illness not listed above? O Yes 0 No If yes _____

Comments:

Patient Dental History

Do your gums bleed while brushing or flossing?	☐ *Yes*	☐ *No*
Do you have any sores or lumps in or near your mouth?	☐ *Yes*	☐ *No*
Have you had any head, neck or jaw injuries?	☐ *Yes*	☐ *No*
Have you ever had any difficulties with extractions in the past?	☐ *Yes*	☐ *No*
Have you ever had any prolonged bleeding following extractions?	☐ *Yes*	☐ *No*
Do you wear dentures or partials?	☐ *Yes*	☐*No*

Name of Previous Dentist _____ *Date of Last Exam*_____

How often are you brushing? _____ *How often are you flossing?*_____

Please describe any current dental problems you may be having

_____

_____

Comments:

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X_____ **Date:** _____

Ebenezer Medical Outreach, Inc.
1448 10th Avenue, Huntington, WV 25701
Phone: 304-529-0753 Fax: 304-529-0591

Authorization for Release of Medical Records

_____ (Print Patients Full Name)

_____ Birth Date (mo/day/yr)

_____ (Street Address)

_____ (Social Security Number)

_____ (City, State, Zip)

_____ (Phone – Home)

At the request of the individual, I _____, do hereby authorize _____ (Name of Doctor that you have seen)

Dates of _____

____	Discharge Summary	____	Pathology Reports	____	Emergency Reports
____	History and Physical	____	Laboratory Reports	__X_	All Records
____	Progress Notes	____	Radiology Reports	____	Other _____
____	Operative Reports	____	ECG/EEG/Cardiac Cath		

____ I do ____ I do **NOT** authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

I give my permission for any confidential information to be released verbally to:

_____ (Name)

_____ (Relationship)

Information Release to _____

_____

_____

Purpose of Disclosure:

____	Referral to Specialist	____	Insurance	____	Workers Comp
____	Change of Physician	____	Legal Investigation	____	Disability Determination
____	Personal	__x_	Continuity of Care	____	Service Management
____	Other _____				

I hereby authorize disclosure of the health information for the above needed patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or the class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign authorization.

_____ Signature of individual or guardian or personal representative of patients' estate

_____ Date

EBENEZER MEDICAL OUTREACH, INC.

We do not provide:

NARCOTICS OR ANY CONTROLLED MEDICATION

(Including anti-anxiety medication such as Xanax, Valium, Ativan, Ultram, Neurontin or Klonopin)

EBENEZER MEDICAL OUTREACH, INC.
Patient Intake Form 2021

Fill out all information.
If you have any questions, please ask office staff.

Name:		**Social Security #:** - -	
Address:			**Date of Birth:**
City:	**State:**	**Zip:**	**County:**
Home Phone:		**Have you been seen here before? Yes No**	
Marital Status Single Married Divorced Widowed	**Sex** Male Female	**Contact Name:**	
Race: Asian Black White Other **Are you a US Citizen?** Yes or No		**Contact Phone:**	

In this section, please list everyone that you live with, including yourself.

Name	Relationship	Date of Birth	Does this person have income? Amount: Employer/Source:
Your Name:	Self		

What is the last year of education completed? _____

Do you receive medical assistance or have insurance coverage?
None _____ Veterans Benefits _____ Medicaid/Medicare _____ Private Insurance _____

I consent to examination, treatment and testing as recommended by the professional staff of Ebenezer Medical Outreach, Inc. (EMO). I understand that, in the normal course of care, health professional students or residents may participate in my care and treatment under the appropriate supervision of licensed health care providers. I agree to have EMO complete any enrollment process, which includes providing financial information, for available patient assistance programs sponsored by pharmaceutical companies to secure my prescribed medications. I also agree if needed, for Astra Zeneca to review necessary records for audit purposes.

I attest that the above information is true and factual.

_____ _____
Date Signature

_____ _____
Date Qualifier

"Our goal is to provide dental patients without health insurance care for pain and infection."

Ebenezer Medical Outreach Inc. Dental Patient Contract

1448 10th Ave. Suite 100 (first floor), Huntington, WV 25701
Phone: (304) 529-0753 Fax: (304) 529-0591

To be qualified for treatment you must be an established patient with Ebenezer Medical Clinic or have a referral letter from an outside primary care physician or local emergency department and complete the Ebenezer Medical Outreach Inc. enrollment process.

You can schedule an appointment by calling the number listed above. Patients are required to pay a $20 Patient Contribution, which is applied to replenishment of supplies, maintaining equipment and other office requirements.

Patients may be refused if they are late or cancel the appointment less than 24 hours before their scheduled time. If you do not cancel on time, then you will be moved to the end of the waiting list. If you miss 2 appointments, then you will be removed from the program for 1 year.

After the initial appointment, because we are not a full-service dental program, the patient will be scheduled with a local volunteer dentist to receive only the MOST ESSENTIAL treatment determined by a professional. If additional appointments are needed you must contact Ebenezer and not the local dental provider's office.

Ebenezer Clinic does NOT provide emergency medical treatment of any kind. You must seek help from your local ER, urgent care facility or a doctor. Ebenezer does NOT provide or prescribe any narcotics or controlled medications. Ebenezer Clinic will provide non-narcotic medications if proven effective for pain management.

All patients must agree to the following conditions to receive treatment:

- ☐ I must verify financial information yearly
- ☐ I must give 24-hour notice to cancel an appointment or lose your spot
- ☐ I will be dismissed from the program for 1 year if 2 appointments are cancelled
- ☐ I must pay $20 Patient Contribution to each appointment
- ☐ I understand that the program is only for ESSENTIAL treatment
- ☐ Ebenezer Dental Staff will schedule all appointments and I will NOT contact the local office
- ☐ I Must respect office policies, be respectful of staff and failure to comply may lead to dismissal from the office
- ☐ I understand that narcotics are not provided or prescribed at Ebenezer Dental Clinic
- ☐ I understand that dental professionals in training may participate in my treatment under the supervision of a license dental provider.

Patient Signature _____ Date _____

COVID-19 Pandemic Dental Treatment Consent Form

I, knowingly and willingly, consent to have dental treatment completed during the COVID-19 Pandemic. I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not, given the current limits in virus testing. Dental procedures create water spray, which is how the disease is spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the COVID-19 virus.

I understand that due to the frequency of 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 a dental office.

_____(Initial)

I confirm I am not presenting any of the following symptoms of COVID-19 listed below:

- Fever
- Shortness of Breath
- Dry Cough
- Runny Nose
- Sore Throat
- Loss of Taste/Smell

_____(Initial)

I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus, and the CDC recommends social distancing of at least 6 feet for a period of 14 days to anyone who has, and this is not possible with dentistry.

_____(Initial)

I verify that I have not traveled outside of the United States in the past 14 days to countries that have been affected by the COVID-19 virus.

_____(Initial)

I verify that I have not traveled domestically within the United States by commercial airline, bus or train within the past 14 days.

_____(Initial)

Name (PLEASE PRINT): _____

Signature_____ Date: _____