Health Care Coalition of Lafayette County
DBA Health Care Collaborative of Rural Missouri
825 South Business Hwy 13, Lexington, MO. 64067 660-259-2440
DBA Live Well Community Health Centers
324 S. Hudson St. P.O. Box 512 Buckner, MO 64016 816-249-1521
1413 N. Jefferson St., Carrollton, MO 64633 660-329-9005
206 N. Bismark, Concordia, MO 64020 660-463-0234
608 Missouri St., Waverly, MO 64096 660-493-2262

August 2018

Dear Parent or Guardian,

Live Well Community Health Centers is happy to announce that we will be offering dental services in your school district again this year. We will bring our mobile dental unit to your childs school and our dental team will perform an initial exam and cleaning. If your child requires additional treatment we will contact you to schedule them.

Would you like your child to receive dental treatment on our mobile unit when we visit your school district?

☐ **YES** ☐ **NO**

If your answer above is "YES", please complete the following registration and consent packet for your child.

If your child is uninsured, we will determine if your family is qualified for our Slide Fee Scale. This scale, which is determined by household income, provides substantial discounts to our dental services. Please call our office at 660.493.2262 and ask to speak with the Outreach Coordinator to discuss the options.

Best Regards,

Live Well Community Health Centers Dental Team
Dr. Geoff Peterson DMD
Dr. David Geiger DMD
Dr. Katie Snodgrass DDS
Dr. Kyle Samples DDS
Kyra Tracy RDH
Caitlin Billings RDH
Liz Rockford RDH
Amber Hostetter, Outreach Coordinator

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Today's Date: _____/_____/_____

Patient Information

Please Print

Patient First Name	Patient Middle Name	Patient Last Name	
Address	City	State	Zip

Date of Birth	Social Security Number	Gender	Age	Grade

Home Phone #	Cell Phone #	Email Address

Person Responsible for Payment

Please Print

Legal Name of Person Responsible		Relationship to Patient	
Address	City	State	Zip

Date of Birth	Social Security Number	Email Address

Home Phone #	Cell Phone #	Work Phone #	Employer

Insurance Information

PRIMARY INSURANCE

Primary Insurance Company Name & Claim Mailing Address	Insurance Phone #	Employer Name

Policy / ID #	Group #	Name of Insured Person	Date of Birth	Social Security #

SECONDARY INSURANCE

Secondary Insurance Company Name & Claim Mailing Address	Insurance Phone #	Employer Name

Policy / ID #	Group #	Name of Insured Person	Date of Birth	Social Security #

Complete other side

The following information is requested by the federal government in order to monitor compliance with federal laws prohibiting discrimination against users of Live Well Community Health Centers. This information will not be used to discrimination you. Your information will be kept confidential.

Emergency Contact Information

Name	Relationship to the Patient	Primary Phone #	Secondary Phone #

AUTHORIZATION FOR SHARED MEDICAL RECORD CONSENT WITHIN LIVE WELL COMMUNITY HEALTH CENTERS:** I understand that my medical and dental records, will be shared by the above stated entities when medically necessary, on a need to know basis. _____*Initials*

**I acknowledge that Live Well Community Health Centers has made available to me the HIPAA NOTICE OF PRIVACY PRACTICES. _____*Initials*

**I hereby authorize Live Well Community Health Centers to provide dental examination services, considered normal and necessary; this may include fillings, extractions and numbing of the mouth/teeth, if needed. _____*Initials*

**I hereby authorize payment directly to Live Well Community Health Centers to release any information required in the course of my examination or treatment necessary to establish an insurance claim. I understand that occasionally my insurance company will deny payment for services that my dentist and or I feel necessary for my overall all health. _____*Initials*

**I agree that I am legally responsible for this patient and I have legal rights to consent to all treatment.

Signature of Responsible Party: _____ Date: _____/_____/_____

Are you interested in applying for the Slide Fee Scale option? **YES NO**

If you answered "Yes", please call the clinic at 660.493.2262 and ask to speak with the Outreach Coordinator for options on how to apply.

2018 Income Verification Table
Family Size and Income Range

Family Size	Slide A	Slide B	Slide C	Slide D	Slide E	Full Pay
1	$0 - $12,140	$11,881 - $15,175	$14,851 - $18,210	$17,821 - $21,245	$20,791 - $24,280	$24,281+
2	$0 - $16,460	$16,021 - $20,575	$20,026 - $24,690	$24,031 - $28,805	$28,036 - $32,920	$32,921+
3	$0 - $20,780	$21,161 - $25,975	$25,201 - $31,170	$30,241 - $36,365	$35,281 - $41,560	$41,561+
4	$0 - $25,100	$24,301 - $31,375	$30,376 - $37,650	$36,451 - $43,925	$42,526 - $50,200	$50,201+
5	$0 - $29,420	$28,441 - $36,775	$35,501 - $44,130	$42,661 - $51,485	$49,771 - $58,840	$58,841+
6	$0 - $33,740	$32,581 -$42,175	$40,626 - $50,610	$48,871 - $59,045	$57,016 - $67,480	$67,481+
7	$0 -$38,060	$36,731 - $47,575	$45,914 - $57,090	$55,096 - $66,605	$64,279 - $76,120	$76,121+
8	$0 - $42,380	$40,891 - $52,975	$51,114 - $63,570	$61,336 - $74,165	$71,559 - $84,760	$84,761+

List ALL members of the Household by Name	Date of Birth	I am FINANCIALLY RESPONSIBLE for Y – YES N – NO	Patient at LWCHC Y - YES N - NO

PATIENT NAME: _____ DATE OF BIRTH _____/_____/_____

YOUR HEALTH HISTORY

Have you been under the care of a physician in the past 2 years? ■ *If yes, please explain:* _____	***YES***	***NO***
Have you been a patient in the hospital in the past 2 years? ■ *If yes, please explain:* _____	***YES***	***NO***
Have you currently or have you in the past taken any Bisphosphonates drug (for Osteoporosis) to prevent bone loss? ■ *If yes, when was the last date medication was taken:* _____/_____/_____	***YES***	***NO***
Are you currently taking any blood thinners, like Coumadin?	***YES***	***NO***
Do you have any bleeding problems?	***YES***	***NO***
Do you smoke or use smokeless tobacco? ■ *If yes, are you interested in quitting?* _____	***YES***	***NO***
Are you currently in or have you ever been in a substance abuse program?	***YES***	***NO***
Have you used street drugs or IV drugs in the past 24 hours? ■ *If yes, please list drugs:* _____	***YES***	***NO***
Do you drink alcoholic beverages? ■ *If yes, how many do you consume daily: 1 - 2 3 - 4 or More*	***YES***	***NO***

Have you ever been diagnosed by a physician as having any of the following? (*Please check all that apply)*

O Artificial Joints	O Heart Attack	O Cancer	O Arthritis
O Pacemaker	O Rheumatic Fever	O Radiation	O Diabetes
O Stents	O High Cholesterol	O Chemotherapy	O Epilepsy
O Anemia	O Thrush/Oral Yeast	O Tuberculosis	O HIV
O Psychiatric Treatment	O Chest Pains	O Stroke	O Hepatitis A
O Kidney Problems	O Reflux Disease	O Asthma	O Hepatitis B
O Constant Cough	O Heart Murmur	O Pneumonia	O Hepatitis C
O Heart Valve Problems	O High Blood Pressure	O AIDS	

MEDICATIONS LIST

We can make a copy if you have a list

_____

_____

_____

_____

ALLERGIES

Are you allergic to any medications? (Penicillin, Aspirin, Codeine or Other) ■ *If yes, please list:* _____	***YES***	***NO***
Are you allergic to latex (rubber)?	***YES***	***NO***
Do you have any other allergies? ■ *If yes, please list:* _____	***YES***	***NO***

WOMEN'S HEALTH

Are you, or do you think you may be pregnant? ■ *If yes, when is your due date:* _____/_____/_____	***YES***	***NO***

DENTAL HISTORY

Why are you seeing a dentist today? (*Please circle all that apply)*

■ Cleaning Toothache Sore Gums Sore Jaw Recent Jaw or Tooth Injury

When did you last see a dentist?

On a scale of 1-10, what is your current level of pain? **LOW** 0 1 2 3 4 5 6 7 8 9 10 **HIGH**

On a scale of 1-10 what is your level of anxiety? **LOW** 0 1 2 3 4 5 6 7 8 9 10 **HIGH**

Does your child suck his/her thumb or fingers?	***YES***	***NO***
Have you ever had abnormal or prolonged bleeding after a tooth extraction?	***YES***	***NO***

X _____ _____ ___/___/___

Patient/Parent/ Guardian Signature **Dentist Signature** **Date**