MyCare Health Center

18 Market Street, Suite C, Mt. Clemens, MI 48043 P: 586.783.2222 F: 586.783.6280
6900 E. Ten Mile Road, Center Line, MI 48015 P: 586.756.7777 F: 586.756.7788 (Medical)
P: 586.467.0980 F. 586.756.7788 (Dental)
42627 Garfield, Suite 213, Clinton Township, MI 48038 P: 586.783.3904 F: 586.783.3906
43740 Groesbeck Highway, Clinton Township, MI 48036 P: 586.493.0961 F: 586.493.1001

Patient Name:_____ **DOB:** _____ **Gender:** Male/ Female

SS#: _____ **Marital Status:** Single _____ Married_____ Divorced _____ Widowed____

Address: _____**Apt:** _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____

Email: _____

If the patient is a minor?

Parent/Guardian Name: _____ **DOB:** _____

SS#: _____ **Gender:** _____

Address: _____**Apt:** _____

City: _____**State:** _____**Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____

Guardianship: (Documentation Required, Circle One) **Legal Guardian** **Court/State Ward**

Or place a checkmark

Emergency Contact: _____ **Relationship:** _____

Phone: _____ **Alternate Phone:** _____

Primary Insurance: _____ **Secondary:** _____ **DENTAL:**_____

Subscribers Name: _____ **Subscribers Name:** _____ **Subscribers Name:** _____

DOB: _____ **Relationship:** _____ **DOB:** _____ **Relationship:** _____ **DOB:** _____ **Relationship:** _____

Social Security #: _____ **Social Security #:** _____ **Social Security #:** _____

Certificate/ID#: _____ **Certificate/ID#:** _____ **Certificate/ID#:** _____

Group #: _____ **Group #:** _____ **Group #:** _____

Group Name:_____ **Group Name:**_____ **Group Name:**_____

Effective Date: _____ **Effective Date:** _____ **Effective Date:** _____

Patient name _____ Birthdate _____

MEDICAL HISTORY

GENERAL HEALTH: ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

☐Y ☐N Under physician/mental health provider's care now? Primary Care Physician's name and phone #:

_____

☐Y ☐N Any hospitalization in the past 5 years?

☐Y ☐N Any serious illnesses/surgeries?

☐Y ☐N Smoker? If Yes, Type:

☐Y ☐N Is pre-medication required before dental visits due to heart condition, artificial joint or any other condition?

☐Y ☐N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*

FEMALE PATIENTS: ☐Y ☐N Currently nursing? ☐Y ☐N Currently pregnant? Due Date:

□ Y □ N Taking Birth control/ Drug name?

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? ☐Y ☐N
If yes, please describe:

Is there anything about your medical condition we have not asked? If yes, please describe:

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ACID REFLUX	☐BULIMIA	☐HEARING PROBLEMS	☐PSYCHIATRIC TREATMENT
☐ADHD	☐CANCER/MALIGNANCY	☐HEART ATTACK	☐RADIATION/CHEMO
☐AIDS/HIV	☐CEREBRAL PALSY	☐HEART DISEASE	☐RESPIRATORY DISEASE
☐ANEMIA	☐CHEMICAL DEPENDENCY	☐HEART MURMUR	☐RHEUMATIC FEVER
☐ANOREXIA	☐CHICKEN POX	☐HEPATITIS	☐SINUS PROBLEMS
☐ANXIETY	☐CONVULSIONS	☐HIGH BLOOD PRESSURE	☐STROKE
☐ARTIFICIAL HEART VALVE	☐DEPRESSION	☐KIDNEY DISEASE	☐THYROID CONDITION
☐ARTIFICIAL JOINTS	☐DIABETES	☐LIVER PROBLEMS	☐TUBERCULOSIS
☐ARTHRITIS	☐DIZZINESS/FAINTING	☐MITRAL VALVE PROLAPSE	☐ULCERS
☐ASTHMA	☐EPILEPSY/SEIZURES	☐MONONUCLEOSIS	☐VENEREAL DISEASE
☐AUTISM/ASPERGER'S	☐FREQUENT EAR INFECTIONS	☐PACEMAKER	
☐BLEEDING DISORDER	☐ FREQUENT HEADACHES	☐OTHER – PLEASE LIST:	

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ASPIRIN	☐CODEINE	☐LACTOSE INTOLERANCE	☐SLEEPING PILLS	NUT/FOOD	☐NONE
☐ANESTHETIC – LOCAL	☐DAIRY	☐METAL SENSITIVITY	☐SULFA DRUGS		
☐BARBITURATES	☐LATEX	☐NITROUS OXIDE SEDATION	☐PENICILLIN/OTHER ANTIBIOTICS		
☐OTHER – PLEASE LIST:					

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ANTIBIOTICS/SULFA DRUGS	☐ANTIHISTAMINES/ALLERGY	☐DAILY ASPIRIN	☐BLOOD PRESSURE MEDICATIONS
☐BLOOD THINNERS	☐CANCER/CHEMO MEDICATIONS	☐CORTISONE/STEROIDS	☐HEART MEDICATION/DIGITALIS
☐INSULIN	☐NITROGLYCERIN	☐PAIN RELIEVERS	☐OSTEOPOROSIS MEDICATIONS
☐OTHER DIABETIC MEDICATIONS	☐RECREATIONAL DRUGS	☐THYROID MEDICATIONS	☐ANXIETY/DEPRESSION/BIPOLAR
☐OTHER (PLEASE LIST BELOW)	☐ SEIZURES		

DRUG NAME	DOSAGE	REASON PRESCRIBED

Patient signature: _____ Date: _____

Reviewed by: _____ Date: _____

MyCare
HEALTH CENTER

Patient Name: _____Date of Birth_____

Provider Name: _____

Patient Questionnaire

We must collect statistics on all the patients we serve because we receive Federal grant funds. Your personal information will be held in the strictest of confidence and is only reported in aggregate form. You have the right to refuse to give this information, however, it may limit the services or programs we are able to deliver to you.

Need affordable Health Insurance or Dental Care? We can help!

1.We assist the uninsured & underinsured obtain health insurance; such as, enrollment in the Market Place Plans or Dental Care. Please indicate which you have interest in. Health Insurance _____ Dental Insurance _____

2. Is English your primary language? _____Yes ____No
If **NO**, what language are you best served in? (This includes sign language or the need for TTY device). _____

3. Please check any living situation you have experienced in the past 12 months:

- ❑ I live in my home which I rent, lease or own.
- ❑ I am staying with friends and/or family members on a temporary basis.
- ❑ I am staying in supportive or transitional housing (such as a sober living facility or recovery home).
- ❑ I live in a public or private facility that provides temporary shelters (such as a shelter, mission, single room or motel).
- ❑ I have been released from an institution (such as jail or hospital) without stable housing to return to.
- ❑ I live on the streets, in a car, park, sidewalk, in an abandoned building, or any other unstable or non-permanent situation.
- ❑ I live in foster care.

4. Are you a Seasonal Agricultural Worker or Migrant Farmer? ____Yes ____No

5. Are you active or reserve military? _____Yes _____No Are you a veteran? _____Yes _____No

6. Are you employed? _____Yes _____No Full/Part Student? ____Yes ____No Full/Part

7. Are you Retired? ____Yes ____No Are you Disabled? ____Yes ____No

8. MyCare offers a Patient Portal where patients can enroll by email to download lab results, request medication refills, pay bills online and much more. Please share your email address if you are interested in using or learning more about this service.
_____@_____.

9. Would you like information on Advance Directives? _____Yes _____No

10. How did you hear about MyCare? ___ Friend/Family ___ Social Media ___ Community Organization ___ Insurance Company
___ Hosp/ ER/ Urgent Care ___ Another MyCare Service ___ Community Event

11. How many members are in your household (including yourself)? _____What is your approximate annual income? _____

12. Are you Hispanic or Latino? ____Yes ____No

Please check the most appropriate box for the following:

13. Race

Asian	
Native Hawaiian	
Other Pacific Islander	
Black African American	
American Indian/Alaska native	
White	
More than one race	

Thank you for your participation. Your answers will help us continue to provide high quality care and services that best meet your needs!

Patient Signature: _____ Date: _____

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Patient Name: _____ **Birth Date:**_____
First Last (MM/DD/YYYY)

General Consent for Dental Treatment

You, the patient, have the right to accept or reject dental treatment recommended by your dentist.

This form documents your consent for yourself or the named minor or other individual for whom you have responsibility, to be treated as a patient of the MyCare Dental Center. This is intended as a general consent. Prior to treatment, your dental provider will explain the anticipated benefits and commonly known and unknown risks of the recommended procedure, alternative treatments, or the option of no treatment. You may be asked to sign additional treatment plan specific consents as recommended by your dental provider. By consenting to treatment, you acknowledge that you understand that you may obtain a second opinion and/or further consultation from another oral health care professional if you so desire. By consenting to treatment, you acknowledge your willingness to accept known risks and complications, no matter how slight the probability of occurrence. By consenting to treatment you acknowledge that at no time have you been provided with any warranty or guarantee as to the specific outcomes of the proposed treatment.

It is very important that you provide your provider with accurate personal and health information before, during, and after treatment. It is equally important that you follow your provider's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your provider, you may increase the chances of a poor outcome.

Please read and initial the items below and sign at the bottom of the form.

1. Treatment to be Provided
   I understand that during my course of treatment that the following care may be provided as deemed clinically necessary by my provider: Examinations, Preventive Services, Urgent and Emergency Services, Restorations, Crowns, Bridges, and other oral health services within the customary primary oral health scope of dentistry.
   Patient Initials _____

2. Care Team
   I understand and acknowledge that my treatment may involve a care team combination of personnel working with and within MyCare Health Centers. I hereby consent to the sharing of information among these entities and their clinical and administrative personnel and to their collaborative provision of my care.
   Patient Initials _____

3. Drugs and Medications
   I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).
   Patient Initials _____

4. Changes in Treatment Plan
   I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during the initial examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.
   Patient Initials_____

5. Billing
   I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable.
   Patient Initials _____

IF THE PATIENT IS AN ADULT

Taking all of the above information into consideration, being at least 18 years of age and otherwise competent to make my own healthcare decisions and fully understanding the nature and possible consequences of treatment and the risks inherent in such treatment, I hereby consent to treatment.

Patient Signature _____ Date _____

IF THE PATIENT IS LESS THAN 18 YEARS OF AGE

I, _____, (INSERT NAME OF PARENT OR LEGAL GUARDIAN) sign this form on behalf of and consent to the treatment explained above to be provided to _____ (INSERT NAME OF PATIENT).

Signature _____ Date _____

IF THE PATIENT IS UTILIZING TELEDENTISTRY SERVICES

I, _____, have reviewed the information above and have received verbal consent to treat.

Signature _____ Date _____

MyCare Patient Appointment Agreement

We value you as our patient and need your cooperation with keeping appointments so that we can provide your care in a timely, high quality manner. We often have more patients who need care than we have room in our daily schedule to accommodate. When a patient does not show up or cancels an appointment too close to his or her scheduled time, we are unable to fill this appointment time with another patient who desperately needs care. If a patient is late for a scheduled appointment, it causes our days to run late and impacts all of our patients. This policy ensures that both you and our other patients receive the care that you need.

MyCare makes every effort to schedule appointments for you that work with your schedule and meet your needs. Once an appointment is made for you, that time is reserved and we expect to see you at the agreed upon date and time. If you are not able to come to your scheduled appointment, you must call us at least 24 hours before your appointment time. If you do not, your appointment is considered a **Broken Appointment**.

The following occurrences are considered a **Broken Appointment**:

- **No Show** – Anytime you have a scheduled appointment and do not show up for the appointment.
- **Late Cancelations** – Anytime you call to cancel an appointment less than 24 hours before the scheduled appointment time.
- **Late Arrivals** – Anytime you arrive more than 15 minutes after your scheduled appointment time. If you are more than 15 minutes late to your scheduled appointment time, you will be placed in Stand-By for the next available time to receive care. It is possible that other patients who are scheduled and have arrived on time will be seen first. We will do our best to see you as soon as possible. Please understand that your wait may be longer than usual and you may see a different provider as schedules allow. If you are more than 15 minutes late for an appointment scheduled during the last hour of the day, we may not be able to see you. If this happens, you will be rescheduled or may come back the next day as a “Stand-By Appointment.”

We keep track of all Broken Appointments. After three (3) broken appointments within a 12-month period, you will be unable to schedule appointments but are welcome to continue getting your care using our “Stand-By Appointment” process. To use a “Stand-By Appointment” you will need to come into the clinic between 8:00 am and 9:00 am. You will be placed on the “Stand-By” list and worked into the schedule as time permits. We will make every effort to see you as quickly as possible. Please understand that you may wait longer than usual and you may see a different provider than usual as schedules allow. Stand-By Appointments are filled for the day on a first come basis.

Many patients use MyCare Health Center services. Your help in keeping your appointments enables us to provide better and timelier care to all of our patients.

_____ _____

Patient or Parent/Guardian Signature **Date**

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www.mycarehealthcenter.org

Acknowledgement of Receipt of Privacy Information Practices

My signature on this form indicates that I have received a Notice of Privacy Information Practices. I also acknowledge that I am aware the Privacy Information Practices are located on the web site above and in the clinic lobby for review.

I the event that I have questions, I have been given the name of the Privacy Officer, whose information is listed below, who will be able to answer my questions.

Privacy Officer
Shari Pierce, Practice Manager
6900 East 10 Mile Rd.
Centerline, MI. 48015
586-756-7777

I request the following restrictions to the use or disclosure of my Protected Health Information. I understand you may or may not agree to my request. I also understand if you agree to the restriction, if the restricted information is needed to provide me with emergency treatment, you may suspend the agreement and provide a health care provider with any needed information.

☐ I do not wish messages left on my voice mail at: _____

☐ I do not wish to be contacted by fax machine.

☐ I do not wish to be contacted by email.

☐ I do not wish to have mail sent to my address on file.

☐ I wish **only** the following person(s) to receive my protected health information.

Name: _____ Relation: _____Birth Date:_____

Name: _____ Relation: _____Birth Date:_____

Other:
_____

_____
Print Name

_____ Date: _____
Signature of Patient or Legal Representative

Office Use Only:

☐ Accepted restrictions

☐ Denied restrictions