SOUTHWEST VIRGINIA
COMMUNITY HEALTH SYSTEMS

Southwest Virginia Regional Dental Center
319 5th Avenue
P.O. Box 729
Saltville, VA 24370
Phone: (276) 496-4433
Fax: (276) 496-4685

Welcome!

We would like to take this opportunity to welcome you to our organization. Our dental team is committed to your total dental care. The mission is to make a positive difference in the lives of children, youth and adults by offering the highest quality, friendly, convenient, and affordable dental care. We are committed to providing the best possible service and accept nearly all insurance plans, Medicaid, FAMIS, and available financing programs. Building a foundation of trust by treating our patients as special individuals is vital to our success. We understand how uneasy some patients may feel about their dental visits and how we can make a difference in providing a relaxing and positive experience. Our entire team is dedicated to providing you with the excellent, personalized care and service to make your visit as comfortable and pleasant as possible. We thank you for allowing us to take care of your dental needs and look forward to serving you. All of our services are integrated to provide you with the best possible outcomes.

Southwest Virginia Community Health Systems, Inc. provides services in Saltville, Tazewell, Meadowview and Bristol VA/TN areas. The services offered are primary medical, dental, vision and behavioral health. Please visit our website, svchs.com, for more detailed information about our services and locations.

Enclosed with this communication are the forms that you need to bring to your first visit. It is very important that you bring your Insurance information and a picture identification card, as well. (A driver's license is preferred).

If you have questions relating to your visit, please feel free to contact our staff at 276-496-4492.

Respectfully yours,
Bryan Haynes, Executive Director

Thank you for choosing Southwest Virginia Community Health Systems, Inc. to handle your healthcare needs.

Please take a few minutes to review and complete the Patient Demographics form as well as the General Consent form.

If you need a slide fee application or would like to review our Privacy policy, they are available on our website www.svchs.com.

Please remember to bring these forms with you to your first visit. We look forward to serving you in the future.

Patient Rights

This health center was created to serve the needs of your community. We want you to be an active part of your treatment here.

- We want you to know what you can expect from us. We want you to be informed about our policies regarding confidentiality, treatment of minors, and other ethical issues. There are some situations, however, when the law itself determines what we must do.
- We want you to know your rights as a patient of this center and to exercise them. A patient who participates in his or her care helps to create a successful outcome.
- You have a right to a reasonable response to your requests for treatment within the scope of the health center's mission, capacity, and regulations.
- You have a right to considerate and respectful care.
- You have a right to confidential treatment. You also have the right to approve or disapprove the release of any disclosures or records, except when release is required by law.
- You have a right to information about your diagnosis, treatments, and prognosis. This information will help you to make informed decisions regarding your care,
- You have the right to prompt and effective pain management and to be informed by staff about available measures.
- You have the right to access any information contained in your medical record.
- You have the right and responsibility to participate in decisions about the intensity and scope of your treatment, within the limits of the health center's mission and applicable laws.
- You have the right to care which takes into consideration your psychosocial, spiritual, and cultural values.
- You have the right to accept medical care, or to refuse treatment, to the extent permitted by law. You also have the right to be informed of the medical consequences of refusing treatment.
- You have the right to participate in the consideration of ethical issues that arise in your care.
- You guardian, next of kin, or legally authorized responsible person can exercise your rights for you if you have been medically or legally determined to be unable to participate yourself.
- You have the right to be informed of any research or experimentation which could affect your care. You may then decide whether or not you want to participate in it.
- You have the right to be made aware of advanced directives and to know how this organization will respond to such advance directives.

This Information about patient rights can be found m: The Joint Commission's Comprehensive Accreditation Manual for Ambulatory Care, 2000.

PATIENT "NO SHOW" POLICY SUMMARY

Our patients are strongly urged to keep their appointments. If you cannot make your appointment, please be sure to call as soon as possible when you know you will not be able to come for your visit. **"No show" patients (those who don't call & cancel/reschedule, without a full 24 hour notice or simply do not show up for a scheduled appointment)**, cause us to hold appointments that would otherwise be used by someone who is ill and may need to be seen by a provider.

SVCHS, Inc.'s policy regarding "no shows" is as follows:

1. **First "no show" occurrence** – Our staff will call to find out the reason for missing your visit and offer to make another appointment for you.
2. **Second "no show" occurrence** – You will receive a letter from our staff warning you of the consequences of not presenting for your visit.
3. **Third "no show" occurrence** – will constitute a "non-compliance issue" which will be discussed with your Care Team. The Care Team determines the severity of the action and determines the outcome. The third "no show" could result in a patient dismissal or necessitate a "Walk-in" only status for the patient. "Walk-in status only" means that if a patient needs to be seen by our providers, they must come into the office at 8:30 a.m. and wait for the first cancellation of the day to be fitted into the schedule.
4. If you are 10 minutes late for your appointment, you will be considered a "no show" and will have to reschedule your appointment for another day.

As partners in your care, we respect and acknowledge the confidence you show in our organization by allowing us to participate in your care. By the same token we ask that you respect us and accept responsibility for keeping your appointments as scheduled.

We look forward to a long and rewarding provider/patient relationship and welcome you to our facility.

Thank you & Welcome!

General Consent

Name: _____ DOB:_____ SSN:_____

1. CONSENT TO FILE INSURANCE/CORRECT INFORMATION
I authorize the release of any and all medical information necessary to process my insurance claims. I permit a copy of the authorization to be used in place of the original. I authorize SVCHS to file my insurance for services rendered. I request that payment be made directly to SVCHS. I certify that the information that I have reported with regard to my insurance coverage and my personal information is correct. I understand that I am responsible for any and all balances that my insurance company does not pay. I understand that claims may be filed electronically through a safety net Internet portal. I understand that I am responsible for all charges incurred regardless of my insurance status or lack thereof. I also understand that I am, as a patient, required to abide by the policies of SVCHS, Inc.

2. HIPPA NOTICE OF PRIVACY POLICY
I acknowledge that I have received and or have read SVCHS's HIPPA Notice of Privacy Policy.

3. CONSENT FOR TREATMENT
I give my consent to the medical staff of SVCHS to perform emergency medical treatment, acute or chronic medical treatment, preventive health care, behavioral/mental health care, and health maintenance care as deemed medically necessary. (If the above named individual is a minor at the time of consent, a parent or legal guardian must sign this consent for treatment.) A "Behavioral Health Consultant" is a member of the primary care team that works closely with your medical provider to recognize and address medical conditions associated with acute and chronic mental and emotional disordered conditions. There is only one electronic health record used between primary care team members in addressing your treatment plan of care and this health information is shared between these primary care team members.
4. SVCHS is serious about the responsibility of keeping your medical and account information private and confidential. In order for us to share any of your information with someone else, you must designate who you want to have access to this information and give us your signed permission to share the information.
a. If we are unable to get in touch with you or someone calls the office about you, please list family members or others we may notify concerning your general medical condition, lab results, test results, other treatment results, or appointment information. If you do not list anyone, then we will not share your private information with anyone else.

Name _____ Relationship _____ Phone# _____ Date _____

Name _____ Relationship _____ Phone# _____ Date _____
b. If you wish to designate someone else to receive information concerning your account and balance information, please list below.

Name _____ Relationship _____ Phone# _____ Date _____

Name _____ Relationship _____ Phone# _____ Date _____
c. If we are unable to contact you and you have an answering machine, do we have your permission to leave a message?

Yes _____ No _____

5.DATA PARTICIPANT may make your medical information available electronically, or may electronically transmit your medical information to a third party, in order to fulfill Data Participant's obligations to release your medical information to others in the future.

PATIENT'S SIGNATURE _____ DATE ____ _____

PARENT/GUARDIAN SIGNATURE _____ DATE_____

WITNESS SIGNATURE _____ DATE_____
(THIS CONSENT FORM WILL BE USED AS NEEDED. YOU MAY REVOKE OR CHANGE ANY OF THE ABOVE CONSENTS AT ANYTIME.)

Interpreter (if necessary)_____ Date:_____
2017 Consent Revised

Appointment Policy

Your dental providers want to make sure that you and other area residents have access to high-quality dental care when you need it. To ensure maximum access to dental services for all of our patients, please be aware of the following Appointment Policy:

Scheduled Appointments: Although we will make every effort to remind you of your upcoming dental appointment by phone or by mail, you are ultimately responsible for remembering your appointment date and time.

Confirming Appointments: We will call you at the number(s) you have provided us at least one day before your scheduled appointment to confirm that you still plan to keep the appointment. If you do not have a working phone or your phone number has changed you should contact us to confirm your appointment.

Canceling Appointments: If you cannot make your scheduled appointment, you must call us at least 24 hours in advance to let us know so that we can offer your appointment to another patient. Failure to provide at least 24 hours' notice counts as a missed appointment.

Late Appointments: If you show up more than 10 minutes late for your scheduled appointment, we will remove your appointment from the schedule and this will be counted as a missed appointment.

Missed Appointments: Because of the critical lack of access to dental services in our area, missed appointments are taken very seriously. If you miss one appointment, you will be documented as having missed an appointment. If you miss three appointments without proper notice within the same calendar year, you will be placed on "no-show status." If you wish to receive further dental care in our clinic, you will be required to call us the day you wish to receive care, and if we have any open appointments, we will be happy to place you in the schedule. If there are no openings that day, you will be advised to call the next day, and so on. Alternatively, we will be happy to place you on our "Quick Call" list, and we will call you when we have an unanticipated opening in the schedule. If you are able to make the appointment that day, we will be happy to provide care. Please understand that if we make a same-day appointment for you and you fail to keep that appointment, you will be discharged from the practice.

Please talk to any of the dental staff if you have questions about our Appointment Policy.

I understand and agree to abide by this No-Show Policy.

Patient Signature: _____Date:_____

Acknowledgement of Receipt of Privacy Practices

**You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

Print Name

Patient Signature: _____ Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt for our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communications barrier prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining the acknowledgement

_____ Other _____

PATIENT DEMOGRAPHIC FORM

PERSONAL INFORMATION:

NAME: _____
First Middle Last

PREFERRED NAME: _____

ADDRESS:_____
PO BOX PHYSICAL ADDRESS/STREET ADDRESS

_____
CITY STATE ZIP

TELEPHONE: HOME_____

CELL_____OTHER_____

EMAIL ADDRESS:_____

DATE OF BIRTH:_____ _____ SEX: Male_____ Female_____

MARITAL STATUS: Single_____ Married_____ Divorced_____ Other_____

SOCIAL SECURITY NUMBER: _____

STUDENT: Full -Time___ Part -Time___ No___

RACE: American Indian or Alaskan Native _____ Asian _____ Black or African American _____
Native Hawaiian or other Pacific Islander _____ White _____ Refused to respond _____

ETHNICITY: Hispanic _____ Non-Hispanic _____ Refused to respond _____

ARE YOU A VETERAN: ____ Yes ____ No

RESPONSIBLE PERSON FOR PAYMENT:
NAME:_____ PHONE:_____

ADDRESS:_____

RELATIONSHIP TO PATIENT:_____

HOMELESS? YES____ NO____ IN TRANSITION? YES____ NO____

EMPLOYMENT INFORMATION:
EMPLOYER NAME:_____
EMPLOYER ADDRESS:_____
EMPLOYER PHONE NUMBER:_____
EMPLOYMENT STATUS: Full-time_____ Part-time_____ Unemployed_____

FINANCIAL INFORMATION - RANGE OF INCOME PER YEAR: ____# of Dependents

_____ I prefer not to give this information

_____ $0 - $5,000	_____ $5,001 - $10,000	_____ $10,001 - $15,000
_____ $15,001 - $20,000	_____ $20,001 - $25,000	_____ $25,001 - $30,000
_____ $30,001 - $35,000	_____ $35,001 - $40,000	_____ $40,001 - $45,000
_____ $45,001 - $50,000	_____ $50,001 - $55,000	_____ $55,001 - $60,000
_____ $65,001 - $70,000	_____ $70,001 - $75,000	_____ $75,001 or higher

Do you feel financially strained? YES_____ NO_____

EMERGENCY CONTACT:

NAME:_____

ADDRESS:_____

TELEPHONE NUMBER:_____

RELATIONSHIP TO PATIENT: _____

INSURANCE INFORMATION:

INSURANCE NAME:_____

SUBSCRIBER NAME:_____

SUBSCRIBER ID# _____

GROUP # _____ EFF. DATE_____

INSURANCE PROVIDED BY EMPLOYER? Yes_____No_____

IS PATIENT COVERED BY INSURANCE? Yes_____No_____

PATIENT RELATIONSHIP TO SUBSCRIBER: _____

SECONDARY INSURANCE (if applicable)_____

SUBSCRIBER NAME:_____ ID#_____

GROUP #_____ EFF. DATE_____

*****IMPORTANT*****

PHARMACY_____ PHONE_____

ADDRESS_____

Translator or interpreter required?:_____Yes _____No_____

Patient (or)
Guardian Signature_____ Date:_____

Please check one:

	PATIENT'S SEXUAL ORIENTATION		**PATIENT'S GENDER IDENTITY**
	Lesbian or Gay		Male
	Straight (not Lesbian or Gay)		Female
	Bisexual		Transgender Male/Female to Male
	Something else		Transgender Female/Male-to-Female
	Don't know		Genderqueer (neither exclusively male or female)
	Choose not to disclose		Other
			Choose not to disclose

Note:

Collection of this information is a requirement for Community Health Centers in reporting to our Federal granting agency. No names will be attached to collection of this data, only the numbers will be reported.

If you do not wish to answer, please use the "Choose not to disclose" option which is the last option on the chart.

Thank you for your cooperation,

Southwest Virginia Community Health Systems, Inc.

2020-02-05 SOGI – final edit

5-19-2022 Demographic-revised

MEDICAL/DENTAL HISTORY

Primary Care Provider: _____Medical Office: _____

Do you require a Pre-Medication Antibiotic? ☐ Yes ☐ No

Do you have allergies to?

☐ Latex ☐ Penicillin ☐ Metal

Other Medications: _____

Others: _____

PLEASE LIST ALL CURRENT MEDICIATIONS (PRESCRIPTIONS, OVER THE COUNTER, AND HERBAL)	

PAST AND CURRENT MEDICAL CONDITIONS

Current and past medical diagnosis (check all that apply)

☐ Hospitalizations/operations in last 5 years	☐ Artificial heart valves	☐ Lung disease	☐ Dialysis	☐ Depression: Diagnosed
☐ Head/neck/mouth injuries	☐ Pacemaker	☐ Emphysema	☐ Eating disorder	☐ Psychiatric disorders (bipolar, PTSD…)
☐ **Women:** pregnant	☐ Indwelling defibrillator	☐ Shortness of breath	☐ Glaucoma	☐ Neurological disease
☐ **Women:** nursing	☐ Artificial joints	☐ Asthma	☐ Stomach: acid reflux	☐ Convulsions
☐ **Women:** oral contraceptives	☐ History of organ transplant	☐ Sleep apnea	☐ Stomach: ulcer	☐ Epilepsy/Seizures
☐ Heart trouble/disease	☐ High blood pressure	☐ Tuberculosis	☐ Sjogren's Disease	☐ Cerebral Palsy
☐ Rheumatic fever	☐ Stroke	☐ Chronic sinus infections	☐ Fibromyalgia	☐ Fainting/Dizziness
☐ Past use of Fenphen	☐ Bleeding problem	☐ Cancer	☐ Autoimmune disease (lupus, pemphigus)	☐ Venereal disease
☐ Heart murmur	☐ Hemophilia	☐ Radiation treatment to head/neck	☐ Arthritis or other joint disorders	☐ AIDS/HIV Positive

☐ Mitral valve prolapse	☐ Anemia	☐ Kidney disease	☐ Frequent headaches	☐ Alcohol or chemical dependency
☐ Heart surgery	☐ Leukemia	Diabetes Type:_____ Controlled: Y N Last A1C: _____ Date of A1C:_____		
☐ Chronic ear infections	☐ TMD/TMJ Disorders	Other (e.g. Food allergies, seasonal allergies etc.): _____		
☐ Thyroid disease	☐ Recreation drugs If yes, would you like information on recover services? ☐ Yes ☐ No	☐ Hepatitis Type: A B C		

Tobacco Use

Do you smoke? ☐ Yes ☐ No

Do you use E-cigarettes? ☐ Yes ☐ No

Do you Vape? ☐ Yes ☐ No How Often? _____If so, does the vape solution contain nicotine or cannabis oil? _____

How much do you smoke per day? _____

Are you a former smoker? ☐ Yes ☐ No

Do you use Dip or Snuff? ☐ Yes ☐ No

Do you want to quit? ☐ Yes ☐ No

Dental History

Date of last dental cleaning and exam? _____

Do you want us to obtain your previous dental records? ☐ Yes ☐ No

Are you in pain today? ☐ Yes ☐ No Level of Pain Scale of 1 -10 _____

Reason for visit today? _____

How often do you brush your teeth? _____

Do you use a hard, medium, soft or extra soft toothbrush? _____

Do you floss? ☐ Yes ☐ No How often _____

How often do you snack between meals? _____

What beverages do you drink between meals? _____ How many? _____

Do you chew or suck on cough drop or hard candies frequently? ☐ Yes ☐ No How many? _____

Do you use a Fluoride toothpaste? ☐ Yes ☐ No

Have you ever been treated for or diagnosed with periodontal disease (gum disease) ☐ Yes ☐ No

Have you ever had an adverse reaction or complication with dental treatment? ☐ Yes ☐ No

Have you ever had oral cancer? ☐ Yes ☐ No

Are you aware of any sores or blisters in your mouth? ☐ Yes ☐ No

Are you aware of any swelling or lumps in the mouth? ☐ Yes ☐ No

Do you have consistent problems with?

Dry Mouth ☐ Yes ☐ No

Sensitivity to Cold ☐ Yes ☐ No

Sensitivity to Hot ☐ Yes ☐ No

Bad Breath ☐ Yes ☐ No

Bad Taste in Mouth ☐ Yes ☐ No

Sore, Bleeding Gums ☐ Yes ☐ No

Loose Teeth ☐ Yes ☐ No

Food Trapping in/between Teeth ☐ Yes ☐ No

Clenching or Grinding ☐ Yes ☐ No

Teeth or Fillings Breaking ☐ Yes ☐ No

Difficulty Chewing ☐ Yes ☐ No

Difficulty Swallowing ☐ Yes ☐ No

Any Additional Information the Dentist Should Know:

_____
_____
_____
_____

5-19-2022 Medical/Dental History-revised

Social Determinants of Health Questionnaire

SVCHS cares about your safety and well-being. Please take a moment to answer the following three questions.

Thank you!

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply.

- ☐ Food
- ☐ Clothing
- ☐ Utilities
- ☐ Child care
- ☐ Medicine or any health care (medical, dental, mental health, or vision)
- ☐ Phone
- ☐ Other (please write in notes)
- ☐ I do not have problems meeting my needs
- ☐ I choose not to answer this question

Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

- ☐ Yes, it has kept me from medical appointments or from getting my medications
- ☐ Yes, it has kept me from non-medical meetings, appointments, work, or getting things needed for daily living
- ☐ No
- ☐ I choose not to answer this question

Do you feel physically and emotionally safe where you currently live?

- ☐ Yes

☐ No
☐ Unsure
☐ I choose not to answer this question

Permission for Telehealth Visits

What is telehealth?

Telehealth is a way to visit with healthcare providers, such as your doctor, nurse practitioner, or dentist.

You can talk to your provider from any place, including your home. You don't go to a clinic or hospital.

How do I use telehealth?

- You talk to your provider by phone, computer, or tablet.
- Sometimes, you use video so you and your provider can see each other.

How does telehealth help me?

- You don't have to go to a clinic or hospital to **see** your provider.
- You won't risk getting sick from other people.

Can telehealth be bad for me?

- You and your provider won't be in the same room, so it may feel different than an office visit.
- Your provider may make a mistake because they cannot examine you as closely as at an office visit. (We don't know if mistakes are more common with telehealth visits.)
- Your provider may decide you still need an office visit.
- Technical problems may interrupt or stop your visit before you are done.

Will my telehealth visit be private?

- We will not record visits with your provider.
- If people are close to you, they may hear something you did not want them to know. You should be in a private place, so other people cannot hear you.
- Your provider will tell you if someone else from their office can hear or see you.
- We use telehealth technology that is designed to protect your privacy.
- If you use the Internet for telehealth, use a network that is private and secure.

- There is a very small chance that someone could use technology to hear or see your telehealth visit.

What if I try telehealth and don't like it?

- You can stop using telehealth any time, even during a telehealth visit.
- You can still get an office visit if you no longer want a telehealth visit.
- If you decide you do not want to use telehealth again:
    - call 276-496-4433 chose your clinic site and say you want to stop
    - It will be as if you never signed this form.

How much does a telehealth visit cost?

- What you pay depends on your insurance.
- A telehealth visit will not cost any more than an office visit for a medical visit. A teledentistry visit could cost more than an in person visit.
- If your provider decides you need an office visit in addition to your telehealth visit, you may have to pay for both visits.

Do I have to sign this document?

No. Only sign this document if you want to use telehealth.

What does it mean if I sign this document?

If you sign this document, you agree that:

- We answered all your questions.
- You want a telehealth visit.

If you sign this document, we will give you a copy.

Your name (please print) Date

Your signature Date

8-13-2021 – Telehealth Form Added