Genesis Healthcare, Inc.

Annual Update Patient Application - Dental

DENTAL PATIENT INFORMATION

Last Name	First Name	M.I.	Social Security #

Address

Home Telephone	Cell Phone	Date of Birth (MM/DD/YYYY)	Age

Email:

☐ Yes! Sign me up for Genesis email updates.

Consent to Call ☐ Yes ☐ No

Consent to Text ☐ Yes ☐ No

Please Check All That Apply

Gender: ☐ Male ☐ Female

Insured's Language: ☐ English ☐ Spanish ☐ Chinese ☐ French ☐ German ☐ Italian ☐ Sign Language ☐ Other_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Life Partner

Race: ☐ African American/Black ☐ White ☐ Asian ☐ American Indian/Alaska Native ☐ Korean ☐ Pacific Islander ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Vietnamese ☐ Samoan ☐ Guamanian or Chamorro ☐ Rather Not Answer ☐ Other_____

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Mexican ☐ Cuban ☐ Mexican American ☐ Puerto Rican ☐ Other_____ ☐ Rather Not Answer

Veteran Status: ☐ Yes ☐ No ☐ Decline

Agricultural Status: ☐ Yes ☐ No ☐ Decline

Homeless Status ☐ Yes ☐ No ☐ Decline

Public Housing ☐ Yes ☐ No ☐ Decline

Student: ☐ Yes, Full Time ☐ Yes, Part Time ☐ No

If yes, Provide School Name:

Current Primary Care Provider: **City/State/Phone**

Current pharmacy:

City/Phone #:

Do you have a provider preference? ☐ YES ☐ NO **Requested Provider:**

Emergency Contact (ages 19 and above):

Name: _____ **Phone #:** _____

Relationship: _____

How did you hear about Genesis Healthcare? Please select one: ☐ Referral; Referral Source: _____

☐ Current Patient ☐ Social Media Advertisement ☐ Newspaper Article ☐ Community Event

Are you interested in serving on the Board of Directors for Genesis Healthcare? ☐ YES ☐ NO

PRIMARY DENTAL INSURANCE

Insured's Name (If other than patient):		Insurance Company:
Address:		
SSN:	DOB:	Employer:

SECONDARY DENTAL INSURANCE

Insured's Name (If other than patient):		Insurance Company:
Address:		
SSN:	DOB:	Employer:

NARCOTIC ACKNOWLEDGMENT

I (Print Name) _____ acknowledge that it has been explained to me that Genesis Healthcare, Inc. does not provide chronic narcotic pain management. This includes the use of narcotic medication as well as other supplemental controlled substances. I understand and agree that I will be referred to another clinic for pain management by that facility's physician.

_____ _____
Patient Signature/Patient Authorized Representative Date

_____
Relationship to Patient if patient unable to sign.

ANSWERING MACHINE/VOICE MAIL MESSAGES

There may be times when our office is not able to reach you by telephone. With your permission, we would like to be able to leave messages on your home answering machine/cell phone voice mail. To comply with strict legal standards, a written release will allow us to leave a message on your answering machine. By signing below, you are authorizing us to leave messages on your answering machine at the telephone number you have given us in your record.

Patient/Patient Authorized Representative Signature: _____

Patient Name (Print): _____ **Date:** _____

Relationship to patient if Unable to Sign: _____

HIPAA AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Some patients prefer other individuals, especially family members, be allowed access to their medical information. To comply with strict legal standards, a written release is required to allow another person access to your medical records. This release grants permission to individual(s) listed below to: Make or confirm appointments, have access to x-ray and laboratory findings, pick up sample medications, be made aware of your diagnosis, prognosis, and treatment plans, and serve as your emergency contact. This permission applies to telephone and answering machine messages as well as other means of communication.

Patient's Signature: _____ **Date:** _____

Patient Print: _____

1. Designated Party: _____

Telephone: _____ **Relationship**_____

CONSENT FOR TREATMENT AND AUTHORIZATION

I, the undersigned, do hereby authorize and consent to dental examinations, x-rays, blood tests/laboratory procedures, invasive or surgical procedures and other medically appropriate services under the general or specific supervision of any member of the medical staff of Genesis Healthcare, Inc for the patient named on this form.

It is understood that this authorization is given in advance of any specified diagnosis, treatment or care being required but it is given to provide authority and power to render care by providers of Genesis Healthcare, Inc. in the exercise of her/his best judgment that they may deem advisable. I understand that state law requires physicians to report certain communicable diseases to the Health Department. SC Code Ann. Sec 44-29-10. Regulation 61-20.

I agree that if I leave a physician's office against the advice of my physician(s) of Genesis Healthcare, Inc and its personnel, they are released from responsibility or liability for any injuries or damages which may result from leaving against medical advice. I authorize a physician of Genesis Healthcare, Inc to test me for HIV antibodies or tuberculosis when the doctor or any employees are exposed to body fluids in a manner which may transmit human immunodeficiency virus (HIV), or infection of tuberculosis. In the event of such an exposure, you will be deemed to have consented to such testing, and to have consented to the release of the test results to the person(s) who may have been exposed.

Patient/Patient Authorized Representative Signature: _____

Patient Name (Print): _____ **Date:** _____

Relationship to Patient if Unable to Sign: _____

Genesis Healthcare, Inc.

HISTORY INTAKE

Dental History

Do your gums bleed when you brush or floss?	Yes	No	Are you experiencing dental pain/discomfort?	Yes	No
Are your teeth sensitive to cold, hot, sweets, or pressure?	Yes	No	Do you grind your teeth?	Yes	No
Is your mouth dry?	Yes	No	Do you have sores or ulcers in your mouth?	Yes	No
Have you had any periodontal (gum) treatments?	Yes	No	Do you wear dentures or partials?	Yes	No
Have you had orthodontic (braces) treatment?	Yes	No	Have you had injury to your head or mouth?	Yes	No
Have you had any problems with previous dental treatment?	Yes	No	Do you have any clicking or popping in your jaw?	Yes	No
Do you have earaches or neck pains?	Yes	No	Do you use tobacco (smoking, snuff, chew)	Yes	No
Do you have an artificial heart valve?	Yes	No	Have you had a heart infection (endocarditis)?	Yes	No
Have you ever had a heart attack (myocardial infarction)?	Yes	No	Other:		

How do you feel about your smile?

Medical History

Anemia	Yes	No	Gout	Yes	No	Osteoporosis	Yes	No
Anxiety	Yes	No	Heartburn	Yes	No	Prostate problems	Yes	No
Arthritis	Yes	No	Heart Problems	Yes	No	Seasonal Allergies	Yes	No
Asthma	Yes	No	High Blood Pressure	Yes	No	Seizures	Yes	No
Autoimmune Disease	Yes	No	High Cholesterol	Yes	No	Skin Problems	Yes	No
Back Problems	Yes	No	Infections (HIV, TB, etc)	Yes	No	Sleep Problems/Apnea	Yes	No
Bone Problems	Yes	No	Kidney Problems	Yes	No	Stomach/Intestine problems	Yes	No
Clotting Disorder	Yes	No	Lung Problems	Yes	No	Stroke	Yes	No
Dementia	Yes	No	Migraines	Yes	No	Substance use	Yes	No
Diabetes	Yes	No	Mental Disorders	Yes	No	Thyroid Disease	Yes	No
Fibromyalgia	Yes	No	Nerve/Muscle Disease	Yes	No	Other:	Yes	No

Medication History

List all Medications (including vitamins, herbs, OTC):
1.
2.
3.
4.
5.
6.
7.
8.
9.

Allergy History

List all Allergies (medication, food, materials)
1.
2.
3.
4.
5.
6.
7.
8.
9.

Surgical History

List of All Surgeries (when & where):
1.
2.
3.
4.
5.

Hospital History

List of Most Recent Hospital Stays (when & where):
1.
2.
3.
4.
5.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Please Fax Records to Attention: _____

I authorize the use and disclosure of my individual health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations. (Note: S.C. Law prohibits the re-disclosure of mental health records).

Patient's Name: _____ Date Requested: _____

DOB: _____ Social Security #: _____ MR#: _____

Person/Organization disclosing the information: _____

Person/Organization receiving the information (Check all that apply):

Location/Department	Address	Phone	Fax
□ Pee Dee Health Care	201 Cashua St. Darlington, SC 29532	843.393.7452	843.393.6210
□ Genesis Healthcare, Darlington (Behavioral Health)	115 Exchange St. Darlington, SC 29532	843.393.9421	843.968.3473
□ Olanta Family Care	211 S Jones Rd Olanta, SC 29114	843.396.9730	843.396.9735
□ Lamar Family Care	301 W Main St. Lamar, SC 29069	843.395.8400	843.395.8401
□ Genesis Healthcare Florence OB/GYN	1523 Heritage Ln. Florence, SC 29505	843.673.9992	843.968.3466
□ Genesis Healthcare Florence Family Medicine and Urology	1523 Heritage Ln. Florence, SC 29505	843.673.0900	843.968.3479
□ Lowcountry Pediatrics	99 Bridgetown Rd. Goose Creek, SC 29445	843.572.3300	833.771.2207
□Walterboro Family Care & Pediatrics	830 Robertson Blvd. Walterboro, SC 29488	843.781.7428	843.781.7429
□ Walterboro Family Care & Pediatrics Dental	830 Robertson Blvd. Walterboro, SC 29488	843.584.4311	843.584.4312
□ Walterboro Family Care Endocrinology	830 Robertson Blvd. Walterboro, SC 29488	843.538.8585	843.538.4777

Information for treatment period: From (Date): _____ To (Date): _____

__Office Notes __Hospital Notes __Laboratory Test __Consults __Radiology Reports __Ancillary Testing Reports __Other (please specify) _____

Purpose(s): __Insurance __Legal Investigation __Disability Evaluation __Continued Care
Other: _____

OR __ I may request my information be released to me to exercise my right to access and obtain a copy of my PHI.

A. I understand that PHI may include records disclosed by health care providers and facilities that previously provided treatment to me.
B. I understand that PHI may include information and records protected under Federal Law (such as alcohol and drug abuse treatment) and/or State Law (such as mental health, AIDS, or HIV).
C. I understand that I may revoke this Authorization at any time. However, the revocation will not apply to PHI that has already been used or disclosed pursuant to this authorization. Contact the Compliance Officer to initiate the revocation process.
D. I understand my treatment by Genesis Healthcare Inc. is not conditioned upon whether I provide authorization for the requested use or disclosure of my PHI.
E. I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal privacy standards.

I have read and understand this Authorization. I certify that I am the Patient listed above or a person authorized to permit release of records on the Patient's behalf. I hereby release Genesis Healthcare, Inc from any liability or damages arising in connection with or related to the use and/or disclosure of my protected health information pursuant to this Authorization.

_____ _____ _____
Patient Name – Print Patient Signature Date

_____ _____ _____
Authorized Representative Relationship to Patient Telephone Number

Patient Financial Self-Attestation Agreement/Acknowledgement

Patient Attestations (please initial)

___ If my application is approved, I request all my medications be filled by a GHC pharmacy.

___ I have the freedom to have my prescriptions filled at any pharmacy and voluntarily choose to use the services of Professional Pharmacy and understand that I can choose another pharmacy whenever I wish by notifying GHC in writing.

___ I acknowledge that I have the freedom of choice to request brand-named medications as my preferred medication, when available, pursuant to South Carolina Law and I request that my prescriptions be filled using brand name drugs when available. This statement and request remain in full force and effect until I request otherwise, in writing.

___ I acknowledge that GHC may obtain Prior Authorizations for brand name medications as authorized by me in this document.

___ I agree and request that GHC process all manufacturer coupons on my behalf.

___ I authorize GHC to deliver or mail my prescriptions to me in the event I am unable to pick them up;

___ I agree to take all medication as prescribed and will notify GHC immediately in the event I am unable to follow prescribed medication instructions.

___ That any self-referral to a non-GHC provider be added to my GHC medical record and the provider to my GHC care team, so that the responsibility of care remains with GHC.

___ I will actively participate in any programs prescribed by my physicians such as Case Management, Disease Management, Preventive Care, wellness programs, and other such programs and/or services; and

___ I certify under penalty of law based on information and beliefs formed after reasonable inquiry, the statements contained in this document are accurate and complete.

I attest that the above information provided to GHC is true and accurate.

Patient/Patient Authorized Representative Signature: _____

Patient Name (Print): _____Date: _____

Relationship to Patient if Unable to Sign: _____