Dental Clinic Intake Form

PLACE LABEL

Information disclosed below allows the SNHD to determine needs/resources for you and the health needs of our community. All information is confidential.

How did you hear about us: ☐ **Current Patient** ☐ **Friend** ☐ **Relative** ☐ **Online** ☐ **Referral**

☐ **Health Fair** ☐ **Facebook** ☐ **Twitter** ☐ **SNHD Website** ☐ **Other** _____

Language most comfortable speaking: _____Do you need an interpreter? ☐ Yes ☐ No
Hearing impaired or need sign language interpreter services? ☐ Yes ☐ No

Emergency Contact(s): _____ **Phone:** _____

Relationship: ☐ **Parent** ☐ **Guardian** ☐ **Spouse** ☐ **Other** _____

WE CARE ABOUT YOUR PRIVACY.

We offer confidential services to all our clients. This means we will not release information about your visit to a friend, parent, guardian or relative without your permission.

I ACKNOWLEDGE THAT I HAVE RECEIVED THE "NOTICE OF PRIVACY PRACTICE." _____ (Initial)

Income Information For Discount Services

☐ I decline to release any income information and accept the cost of non-discounted services
☐ I have no income ☐ I am unemployed ☐ I am homeless

What is **your** weekly **income before taxes**? Hourly rate of pay _____ Number of hours you work per week _____	
What is your partner/spouse's weekly income **before taxes**? Hourly rate of pay _____ Number of hours you work per week_____	
Any other income (Tips, SSI, etc.) to report? ☐ Yes ☐ No List type and amount:	
If you do not have income, please explain how your basic needs are paid for:	
Amount of total weekly income?	
How many people are supported by this income?	

Office Use Only

Sliding fee category: ____
Reviewed by: _____

Referred for Hardship:
Date: _____
Initials: _____

Ref. to EW re services:
Date: _____
Initials: _____

Consent for Medical Treatment

I give my consent to the medical staff of the Southern Nevada Health District's Clinical Services Programs/Clinics to examine, obtain necessary lab work, treat and counsel me or my child. I understand that there are certain hazards and risks connected with all forms of treatment and care, and with this knowledge, I give my consent. I understand that if I am treated for or diagnosed with a sexually transmitted infection the clinic is required by law to report this to certain public health agencies. I understand that clinic staff may also be required by law to report some claims of physical or sexual abuse. I hereby certify that I have read and fully understand the above consent for testing and/or treatment. After evaluation, if my medical condition is beyond the capacity of SNHD services, I will be referred elsewhere for further care.

I have answered all the questions correctly to the best of my knowledge.

_____ _____ _____
Print Name **Signature** **Date**

Relationship: ☐ **Self** ☐ **Parent** ☐ **Guardian** ☐ **Other** _____