

## Registration Form

Demographics		
Last name:	First:	Middle:
Preferred name:	Name at birth or other names:	
Sex (legal):	<input type="checkbox"/> Male	<input type="checkbox"/> Female
	<input type="checkbox"/> Nonbinary	<input type="checkbox"/> X
Gender Identity:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
	<input type="checkbox"/> M to F	<input type="checkbox"/> F to M
	<input type="checkbox"/> Other: _____	
Birth date: ( <i>month/date/year</i> )	Social Security Number:	
Street address:		
City:	State:	ZIP Code:
Mailing address: ( <i>if different from your home address</i> )		
City:	State:	ZIP Code:
Cell Phone:	Work Phone:	
Home Phone:	Other:	
Do we need to contact you at a different mailing address, phone number, or through an alternate method for confidential issues? <input type="checkbox"/> No <input type="checkbox"/> Yes, _____		
Marital Status: <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Other: _____		
What is your primary language? _____	Do you need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Ethnicity:	Race: ( <i>mark all that apply</i> )	
<input type="checkbox"/> Cuban	<input type="checkbox"/> Alaskan Native	<input type="checkbox"/> Other Asian
<input type="checkbox"/> Mexican, Mexican American, Chicano/a	<input type="checkbox"/> American Indian	<input type="checkbox"/> Other Pacific Islander
<input type="checkbox"/> Puerto Rican	<input type="checkbox"/> Asia Indian	<input type="checkbox"/> Guamanian or Chamorro
<input type="checkbox"/> Another Hispanic Latino/a or Spanish Origin	<input type="checkbox"/> Black/African American	<input type="checkbox"/> Samoan
<input type="checkbox"/> Multiple Hispanic, Latino/a, or Spanish Origins	<input type="checkbox"/> Chinese	<input type="checkbox"/> Vietnamese
<input type="checkbox"/> Non-Hispanic or Latino/a	<input type="checkbox"/> Filipino	<input type="checkbox"/> White
<input type="checkbox"/> Patient Refused	<input type="checkbox"/> Japanese	<input type="checkbox"/> Patient Refused
<input type="checkbox"/> Unknown	<input type="checkbox"/> Korean	<input type="checkbox"/> Unknown
	<input type="checkbox"/> Native Hawaiian	
Emergency Contact		
Name:	Relationship:	
Phone:	Alternate Phone:	
Legal Guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Guarantor (person responsible for payment)		
Last name:	First:	Middle:
Last Name at Birth:	Date of Birth: ( <i>month/date/year</i> )	
Billing Address:		
City:	State:	ZIP Code:
Relationship:		

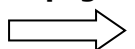


## Benton County Dental Services

### Dental Health History

<b>Patient's Dental Health</b>					
<b>Patient Name</b>				<b>DOB</b>	
Are you currently experiencing pain? <input type="checkbox"/> Yes <input type="checkbox"/> No		When was your last dental exam?			
if yes, please provide details:					
Do you have difficulty opening your mouth?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Do you clench or grind your teeth?	
Do you have difficulty chewing?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Do you have dry mouth?	
Does your jaw click, pop, or lock open?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Are your teeth sensitive to hot or cold?	
Do you have history of sores or growths in your mouth?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do your gums bleed when you brush or floss your teeth?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does dental treatment make you nervous?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you had any injury to your face or mouth?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever had problems with dental treatment or dental anesthetic?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does your PCP require you to pre-med before dental treatments?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever taken Fen-Phen or Redux?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever taken Bisphosphonates (Fosmax, Boniva, Actonel, Aredia, Zometa, ect.)?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Patient's Medical History</b>					
ADD/ADHD		<input type="checkbox"/> Yes <input type="checkbox"/> No		COPD	
Alcoholism		<input type="checkbox"/> Yes <input type="checkbox"/> No		Depression	
Allergies		<input type="checkbox"/> Yes <input type="checkbox"/> No		Diabetes	
Anemia		<input type="checkbox"/> Yes <input type="checkbox"/> No		Drug addiction	
Anxiety		<input type="checkbox"/> Yes <input type="checkbox"/> No		Emphysema/COPD	
Arthritis/Joint disorder		<input type="checkbox"/> Yes <input type="checkbox"/> No		Glaucoma	
Asthma		<input type="checkbox"/> Yes <input type="checkbox"/> No		Heart disease	
Autism		<input type="checkbox"/> Yes <input type="checkbox"/> No		Heart failure	
Bisphosphonate therapy		<input type="checkbox"/> Yes <input type="checkbox"/> No		Heart murmur	
Broken jaw		<input type="checkbox"/> Yes <input type="checkbox"/> No		Heart endocarditis	
Cancer		<input type="checkbox"/> Yes <input type="checkbox"/> No		Blood transfusions	
Cataracts		<input type="checkbox"/> Yes <input type="checkbox"/> No		HIV/AIDS	
Clotting disorder		<input type="checkbox"/> Yes <input type="checkbox"/> No		Hyperlipidemia	
Congenital heart defect		<input type="checkbox"/> Yes <input type="checkbox"/> No		Hypertension	
Kidney disease				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Liver disease		<input type="checkbox"/> Yes <input type="checkbox"/> No		Meningitis	
Mental health disorder		<input type="checkbox"/> Yes <input type="checkbox"/> No		MRSA infection	
Myocardial infarction		<input type="checkbox"/> Yes <input type="checkbox"/> No		Nerve/muscle disease	
Osteoporosis		<input type="checkbox"/> Yes <input type="checkbox"/> No		Pacemaker	
Seizures		<input type="checkbox"/> Yes <input type="checkbox"/> No		Sickle cell anemia	
STD		<input type="checkbox"/> Yes <input type="checkbox"/> No		Stomach Ulcers	
Stroke		<input type="checkbox"/> Yes <input type="checkbox"/> No		TB Disease	
Thyroid disease		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you have implants/Artificial joints?		<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, what joint? <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Other: _____	
Have you had a major surgery?		<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, what year? _____ Type of operation _____	
Have you consumed alcohol with in the last 24 hours?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you smoke or use chewing tobacco?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, how much per day? _____				How many years? _____	
<b>Women:</b> Are you taking birth control meds? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Are you or could you be pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No					

**Continue next page**





**Physicians Name: (If not part of Benton County Health Services)**

---

**Medications**

Medication:	Condition:
Medication:	Condition:
Medication:	Condition:
Medication:	Condition:
Medication:	Condition:
Medication:	Condition:
Medication:	Condition:
Medication:	Condition:
Medication:	Condition:
Medication:	Condition:

---

**Allergies**

Aspirin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ibuprofen	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sulfa Drugs/Sulfites/Sulfides	<input type="checkbox"/> Yes <input type="checkbox"/> No	Penicillin	<input type="checkbox"/> Yes <input type="checkbox"/> No
Codeine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amoxicillin	<input type="checkbox"/> Yes <input type="checkbox"/> No
Local anesthetics	<input type="checkbox"/> Yes <input type="checkbox"/> No	Latex, Metals, Plastics	<input type="checkbox"/> Yes <input type="checkbox"/> No

Other medications allergies:

---

**Patient Signature**

_____	_____
Patient signature	Date
_____	_____
Provider signature	Date

Community Health Centers of Benton and Linn Counties is able to help our patients offset the cost of health services due to grant support from the government. As a result we are required to gather income and housing information for each of our patients. We realize this is very personal information and we will continue to protect your confidentiality with this information as well as with your personal health information.

Employment Information
Have you or anyone else in your household worked in any of the following industries during the last two years? Please check all that apply:
<input type="checkbox"/> Orchards
<input type="checkbox"/> Packing house (fruits, vegetables, gift boxes)
<input type="checkbox"/> Reforestation / tree planting
<input type="checkbox"/> Vineyards
<input type="checkbox"/> Crops / harvesting (fruit, vegetables, flowers, trees, mushrooms, etc.)
If you checked any of the above boxes, did your work ever require your family to move? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been a member of the armed forces? <input type="checkbox"/> Yes <input type="checkbox"/> No
Employer(s) (optional):

Housing Information
Are you and your family members living in someone else's household? <input type="checkbox"/> Yes <input type="checkbox"/> No
In the past 24 months, have you and your family been forced to move into a temporary situation because of housing costs? <input type="checkbox"/> Yes <input type="checkbox"/> No
In the past 24 months, have you or someone in your household lived in one of the following: <input type="checkbox"/> Shelter <input type="checkbox"/> Transitional housing <input type="checkbox"/> Camp or street

Insurance Information			
Do you have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/> I am uninsured or have insurance with a very high deductible and would like to apply for the sliding fee scale to help cover the cost of my visits. (You may be asked to provide verification of your income by providing check stubs or income tax documents.)			
Name of Primary Insurance:			
Insurance Mailing Address:			
City:	State:	ZIP code:	Phone:
Name of Policy Holder:	Relationship to Client:		
Mailing Address:	Phone:		
Insurance ID:	Group #:		
Do you have additional insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			