Chart # _____

Aloha Medical Mission

Quest/Medicaid:	Short-call:	Condition/Premeds:	Allergies:	Date:

HEALTH HISTORY FORM

Name: Last First Home Phone: ( ) Business Phone: ( )

Address: City: State: Zip Code:

Marital Status:
□ Single □ Married □ Divorced □ Widowed □ Minor Height: Weight: Date of Birth: Sex: M □ F □

Immigrant? □ Yes □ No If Yes, Date of Arrival: Country of Origin:

Ethnicity (Please select the **ONE** you most identify with):
□ African American □ Chinese □ Fijian □ Part Hawaiian □Japanese □ Maori □ Native American □ Samoan □ Vietnamese
□ Caucasian □ Chuukese □ Filipino □Hispanic/Latino/Spanish □Korean □ Marshallese □ Portuguese □ Tongan □Other:_____

Employer: Occupation:

If you are completing this form for another person, what is your relationship to that person?

NAME RELATIONSHIP
Emergency Contact: Relationship: Phone: ( )

How did you hear about Aloha Medical Mission?

Do you have dental insurance: □ Yes □ No If yes, under what company? Policy #:

Do you have Healthcare insurance: □ Yes □ No If yes, under what company?

Do you have Quest/Medicaid? □ Yes □ No

MEDICAL INFORMATION

	Yes	No	Don't Know
If you answer yes to any of the 3 items below, please stop and return this form to the receptionist.			
Have you had any of the following problems?			
Active Tuberculosis	□	□	□
Persistent cough greater than a 3 week duration	□	□	□
Cough that produces blood	□	□	□
Are you in good health?	□	□	□
Are you now under the care of a physician?	□	□	□

If yes, what is/are the condition(s) being treated?

List any medication (Prescribed/Over The Counter/Supplements) and dosages are you taking.

List any allergies to medication, antibiotics, latex, local anesthetics, metals, food/other allergies and your reaction. Or Check No Known Allergies □

WOMEN ONLY

Are you or could you be pregnant?	□	□	□
Nursing?	□	□	□
Taking birth control pills or hormonal replacement?	□	□	□

Please (X) a response to indicate if you have or have not had any of the following diseases or problems, explain in the space provided below.

	Yes	No	Don't Know
Anemia/ Abnormal Bleeding/ Hemophilia	□	□	□
Arthritis/ Osteoporosis/ Bisphosphonate Usage	□	□	□
Asthma/ Lung Disease/ Respiratory Problems/ Tuberculosis	□	□	□
Autoimmmune Disease/ Lupus / Skin Diseases	□	□	□
Cancer/ Chemotherapy/ Radiation/ Immunosuppression	□	□	□
Cardiovascular Disease/ Heart Disease/ Condition/ Pacemaker	□	□	□
Chronic Pain/ Fibromyalgia/ Headaches	□	□	□
Diabetes (Please circle): Type I / Type II / Gestational	□	□	□
Eye Disease/ Glaucoma	□	□	□
Gastrointestinal Disease/ Acid Reflux / Eating Disorder	□	□	□
High Blood Pressure/ Low Blood Pressure/ High Cholesterol	□	□	□
Infectious Diseases (AIDS, HIV, STDs, etc.)	□	□	□
Kidney Problems/ Dialysis	□	□	□
Liver Disease/ Hepatitis/ Jaundice	□	□	□
Oral/ Dental Diseases/ Disorders/ Neck Swelling	□	□	□
Prosthetic Joints	□	□	□
Seizures/ Fainting/ Mental/ Neurological Problems	□	□	□
Stroke/ TIA	□	□	□
Thyroid Problems	□	□	□
Tobacco, Alcohol, or Drug Use	□	□	□

Explain any "yes" responses:

Do you have any disease, condition, or problem not listed above that you think the dentist should know about? Please explain:

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

FOR COMPLETION BY DENTIST

Health History Update: On a regular basis the patient should be questioned about any medical history changes, date and comments notated, along with signature.

Date	Comments	Signature of patient and dentist

Revision 3/5/2013

Aloha Medical Mission Dental Clinic Patient Eligibility Verification Form

Please check Yes or No for the following questions:

1. Does the patient have dental insurance? Yes □ or No □ If yes, name of insurance:_____

If you answered YES to the question above, please STOP and turn form in to receptionist.

2. Does the patient have Quest? Yes □ or No □

3. Is the patient a Hawai'i resident? Yes □ or No □

NOTE: **The following items are EXCLUDED as countable income:**

- Loans
- Food stamps
- Scholarships and grants to undergraduate or graduate students

4. Type of documentation of income given (e.g. paystubs, DHS income):

_____

Documentation of income is required by the patient's second visit in order to be seen at Aloha Medical Mission Dental Clinic. If this is your first visit please fill out questions 5 and 6.

5. How many people live in your household? _____

6. Household's total monthly income: _____

7. Is the patient currently unemployed? Yes □ or No □

If unemployed, is the patient receiving unemployment benefit payments? Yes □ or No □

8. Is the patient homeless and not living in a place of residence? Yes □ or No □

If yes, what is the current address or location of stay? _____

I certify that the above information is true to the best of my knowledge as of this date.

_____ _____

Signature of Patient OR Guardian Date

_____

Name of Patient OR Guardian (print)

_____ _____

Signature of Verifying Officer (AMM Staff Only) Date

ALOHA MEDICAL MISSION CLINIC
PALAMA SETTLEMENT
810 N. Vineyard Blvd., Honolulu, Hawaii 96817
Telephone: (808) 841-4489 Fax: (808) 847-3443

Aloha,

We are glad to have you at Aloha Medical Mission. Before proceeding with your treatment, there are a few things you need to know about Aloha Medical Mission Clinic.

1. We are an Interim Clinic – This means we are only a temporary home until you can find insurance and/or a permanent dental home. We do not do long term dental care.
2. Keeping your appointment is very important to us. If you are unable to make your scheduled appointment, please call to inform us ahead of time. If you do not have a valid reason for missing the appointment, AMM will no longer reserve an appointed time for you. Instead, we will encourage you to walk-in in order to receive services if a dentist is available.
3. You are given up to three no-shows. Once you have reached this limit, we regret to say that AMM will not be able to offer treatment to you.
4. We are only equipped to do basic dental procedures including Exam, Cleaning, Filling, Extraction, and Temporary Treatment. We cannot do root canals or dentures. If you require a procedure that we do not provide here, you will be provided with information for the low-cost dental clinics.
5. Most of the dentists that provide treatment at AMMC are volunteers. Each dentist at AMMC is licensed by the state of Hawaii to practice dentistry.
6. Because the clinic is staffed by volunteers, we have limited and varying hours. Occasionally a dentist may need to cancel his scheduled date due to unforeseen events. If this happens, we will try to give as much notice as possible.
7. Staff may take pictures during dental procedures. If you do not want us to take photos which may be used for advertisement, please check the following box. □
8. The clinic is a learning site for dental assisting students and dental hygiene students. You may have students observing while the dentist sees you.
9. If you would like to be placed on our short call list please check the following box. □ Those on short call list will be contacted if there is an opening in our schedule. Patients must be able to come to the clinic within 10 minutes of being notified.

I have read and understand the conditions established by Aloha Medical Mission Clinic. I agree to abide by the guidelines outlined herein.

_____ _____

Signed Date

_____

Printed Name

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CONSENT, INDEMNITY, WAIVER AND RELEASE

I, _____ (Patient/Parent/Legal Guardian), hereby request and voluntarily seek health screening and/or testing to be rendered by the volunteers of Aloha Medical Mission Clinic for

_____
(Patient's Name)

I understand that I will not be charged for these services. However, if there is health insurance, I understand that I/my child should return to the primary care provider for further treatment and care.

I hereby indemnify and release Aloha Medical Mission Clinic, its directors, officers, and volunteers from any and all liability whatsoever, arising from my/my child's care and treatment.

Further, I understand that:

1. the data derived from such examinations/tests are to be considered as preliminary and are not conclusive;
2. the responsibility for setting up any follow-up examinations for any disease or abnormal condition identified belongs solely to me;
3. designated Aloha Medical Mission Clinic personnel and volunteers shall have access to my/my child's test results and records for the sole purpose of making sure whether the results are normal and assisting me in setting up a follow-up examination or treatment; and
4. no other individual or agency shall have access to my/my child's records and individual test results without my permission. Collected data may be used for statistical and research purposes;
5. if and when appropriate, I/my child may submit to treatment provided by the Aloha Medical Mission Clinic staff and volunteers.
6. pursuant to Act 250, Hawaii Revised Statutes, Section 90-1: ..."Without limiting the generality of the foregoing, the term "volunteer" specifically includes any health care provider accepted in writing by the department of health as a "volunteer" who provides free medical or dental treatment, diagnosis, or advice to indigent, and medically underserved patients, whether acting individually or in cooperation with a nonprofit organization."

I have read and understand the above and hereby indemnify and waive any and all liability, claims and causes of action against Aloha Medical Mission Clinic, its directors, officers, and their volunteers.

_____ _____
Signature (Patient/Parent/Legal Guardian) Date

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FREE CLINICS FEDERAL TORT CLAIMS ACT (FTCA) PROGRAM

Patient Notice of Limited Liability of FTCA Deemed Volunteer
Free Clinic Health Care Professionals

Notice to Patients

This form is given to the individual patient before health care services are provided, except in emergency cases when notice may be provided as soon after the emergency as is practicable or to a parent or legal guardian when the patient lacks legal responsibility for his/her care under State law.

This is to notify you that under Federal law relating to the operation of free clinics, the Federal Tort Claims Act (FTCA), (See 28 U.S.C. §§ 1346(b), 2401(b), 2671-80) provides the exclusive remedy for damage from personal injury, including death, resulting from the performance of medical, surgical, dental, or related functions by any free clinic volunteer health care practitioner who the Department of Health and Human Services has deemed to be an employee of the Public Health Service. This FTCA medical malpractice coverage applies to deemed free clinic volunteer health care practitioners who have provided a required or authorized service under Title XIX of the Social Security Act (i.e., Medicaid Program) at a free clinic site or through offsite programs or events carried out by the free clinic (See 42 U.S.C. § 233(a), (o)).

Certain free clinic health care professionals providing health care services to patients at this free clinic may be covered by the above Federal law.

Acknowledged: _____ Date _____
Signature (Patient/Parent/Legal Guardian)

_____
(Printed Name and Relationship to Patient)

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Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of Provider's Notice of Privacy Practices with the effective date of _____.

_____ _____
Signature of Patient/Patient Representative Date

_____
Relationship to Patient