Chart #________________ **Aloha Medical Mission** Quest/Medicaid:

HEALTH HISTORY FORM

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

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?	Yes	No
Active Tuberculosis	□	□
Persistent cough greater than a 3 week duration	□	□
Cough that produces blood	□	□

	Yes	No
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) and circle to indicate if you have had any of the following diseases or problems, explain in the space provided below.

	Yes	No
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

Aloha Medical Mission Dental Clinic Patient Eligibility Verification Form

Documentation of income is required at the patient's first visit, and then annually after, to be seen at Aloha Medical Mission Dental Clinic. If this is your first visit, please fill out the questions below.

1. Are you receiving any of the following? **(CHECK ALL THAT APPLY)**
   - □ Unemployment Insurance
   - □ Supplemental Nutrition Assistance Program (SNAP)
   - □ Temporary Assistance for Needy Families (TANF)
   - □ Supplemental Security Income (SSI) Benefits
   - □ Housing or Utility Assistance
   - □ Child Support
   - □ Alimony
   - □ Pension
   - □ Financial Assistance from Friends & Family
   - □ Other, if not listed above please state all other financial assistance you receive:
     ____
     ____
     ____

2. How many people live your household/are you financially responsible for? ___________
3. Household's total monthly income: ____
4. Is the patient homeless and not living in a place of residence? Yes ☐ or No ☐
5. If yes, where 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.

____

Name of Patient OR Guardian (Print)

_____________________________________ _________________

Signature of Patient OR Guardian Date

_____________________________________ _________________

Signature of Verifying Officer (AMM Staff Only) Date

200 N. Vineyard Blvd. Suite B120, Honolulu, Hawaii 96817
Telephone: (808) 847-3400 Fax: (808) 847-3443
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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 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 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)

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

COVID-19 SCREENING QUESTIONNAIRE

In order to prevent the spread of the coronavirus and reduce the potential risk of exposure to our workforce we are asking anyone entering the clinic to submit the following. **Please respond to each of the following questions truthfully and to the best of your ability.** Your participation is important to help us take precautionary measures to PROTECT YOU and our employees.

Name:	Date:
Phone Number (mobile/home):	Email:

	Representations
1.	Are you currently experiencing, or have you experienced in the past 14 days, any of the following symptoms? (***Please take your temperature before you answer this question.)*** Yes ☐ No ☐ Fever (100.0° F/37.8° C or greater as measured by an oral thermometer) Yes ☐ No ☐ Cough Yes ☐ No ☐ Shortness of breath or difficulty breathing Yes ☐ No ☐ Sore throat Yes ☐ No ☐ New loss of taste or smell Yes ☐ No ☐ Chills Yes ☐ No ☐ Head or muscle aches/Dizziness Yes ☐ No ☐ Nausea, diarrhea, vomiting
2	In the past 14 days, have you been in close proximity to anyone who was experiencing any of the above symptoms or has experienced any of the above symptoms since your contact? Yes ☐ No☐
3	In the past 14 days, have you been in close proximity to anyone who has tested positive for COVID-19? Yes ☐ No☐
4	Have you been tested for COVID-19 and are waiting to receive test results? Yes ☐ No☐ If yes, please provide the date of your COVID-19 test:
5	Have you have tested positive for COVID-19, or are you presumptively positive for COVID-19 based on your health care provider's assessment or your symptoms? Yes ☐ No☐ If yes, please provide the date of your positive COVID-19 test result:
6	In the past 14 days, have you been on a commercial flight or traveled outside of the United States? Yes ☐ No☐
7	In the past 14 days, have you been in close proximity to anyone who has been on a commercial flight or traveled outside of the United States? Yes ☐ No☐
8	Is there any reason why you feel you are at higher risk of contracting COVID-19 or experiencing complications from COVID-19 by entering the facility? If "yes", please provide a brief explanation. Yes ☐ No☐ Explanation:

I hereby certify that the responses provided above are true and accurate to the best of my knowledge.

Signature: Date: / /