PATHS
Live Life. Be Healthy.

PATHS Community Dental Center

380 Washington Street
Boydton, VA 23917
Phone: 434-738-6332
Fax: 434-738-6330

501 Rison Street, Suite 110
Danville, VA 24541
Phone: 434-791-0214
Fax: 434-791-0217

30 S Main Street
Chatham, VA 24531
Phone: 434-432-4443
Fax: 434-432-8072

www.pathsinc.org

PATHS Community Dental Center is a general dentistry facility offering affordable dental treatment for adults and children. We accept all dental insurance including DentaQuest (Medicaid Virginia Premier). For those who do not have dental insurance we offer a sliding scale based on household income and the number of people living in the home.

Registration Information:

- **Hours: Paper work can be picked up and dropped off any time during hours of operation. The dental staff will process the applications on Fridays 8:30 – 3:30**
- New patients will need to be registered **before** scheduling appointments.
- **Only** complete registration packets will be scheduled appointments.

Complete registration packets include:

- Proof of Household Income Pay stubs (choose **one**)
    - A) 1 month of most recent (4 stubs if paid weekly, 2 stubs if paid bi-weekly, or 1 stub if paid monthly),
      B) W-2 forms from the previous year's tax return or previous year's tax return,
      C) Social Security Retirement
      D) Documentation of income from pension accounts.
- No income proof —The SNAP acceptance letter, or any organization that uses income as a qualification. A family member, friend, significant other, minister, etc. who would be willing to verify that the patient has no income at this time.
- Dental Insurance or Medicaid Card- bring card(s) to verify eligibility.
- Medication List: Need name of medicine, strength, direction on how taken, what condition taken for, doctors name and phone numbers.

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Today's Date: ___/___/____

Which services are you interested in? ☐ Medical ☐ Dental ☐ Women's Health ☐ Behavioral Health ☐ MEDAssist ☐ Pharmacy

Who would you like to choose as your primary care provider? _____

What pharmacy do you prefer to use? ☐ PATHS Community Pharmacy ☐ Other _____

A. Patient Information

Name: _____ **Email**: _____

Address: _____ **City**: _____ **ST**: ____ **Zip**: _____
Do you live in public housing? ☐ Yes ☐ No ☐ Homeless

Phone (Home): _____-_____-_____ (**Cell**): _____-_____-_____ (**Work**): _____-_____-_____

Social Security Number: _____-_____-_____ **Date of Birth**: ____/____/_____

Birth Sex: ☐ Male ☐ Female

Gender Identity: ☐ Male ☐ Female ☐ Transgender - Male to Female ☐ Transgender - Female to Male ☐ Genderqueer, neither exclusively male or female ☐ Choose not to disclose

Sexual Orientation does not apply to patients under 18 years of age
Sexual Orientation: ☐ Straight (not lesbian or gay) ☐ Lesbian or Gay ☐ Bisexual ☐ Choose not to disclose ☐ Do not know ☐ Something Else, please describe _____

Race (check all that apply): ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White ☐ Japanese ☐ Declined to Specify

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Declined to Specify

Preferred Language: ☐ English ☐ Spanish ☐ Other _____ ☐ Interpreter Needed

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

Accessibility Needs: ☐ Hearing Impaired ☐ Vision Impaired ☐ Interpreter Needed

Employment Status: ☐ Employed Full Time ☐ Employed Part-Time ☐ Unemployed ☐ Self Employed ☐ Retired ☐ On active military duty

Employer (or Name of School if Minor): _____

Are you a student? ☐ Yes ☐ No If yes, ☐ Full-Time ☐ Part-Time

Are you a veteran: ☐ Yes ☐ No

Are you a migrant/seasonal worker? ☐ Yes ☐ No

How do you prefer to be contacted? ☐ Mail ☐ Phone ☐ Email ☐ In Person

I authorize PATHS Community Medical Center to leave messages related to my care on my answering machine/voicemail ☐ Yes ☐ No

B. Responsible Party

Name of Person Responsible for this account: _____

Phone: (H) (_____) ___-____ _____Cell: (_____) ___-_____

Relationship to Patient: _____ **Birthday**: ___/___/___ SS **Number**: _____-_____-_____

Address: _____ **City**: _____ **ST**: ____ **Zip**: _____

Is this person also a patient in another of PATHS services? ☐ Yes ☐ No If yes, which one _____

C. Insurance Information

Primary Insurance
Name of Insured: _____ **Relationship to Patient**: _____ **Birthday**: ____/____/____

SS Number: _____-_____-_____ **Insurance Company**: _____

Subscriber Number: _____ **Do you have prescription coverage? ☐ Yes ☐ No**

Secondary Insurance
Name of Insured: _____ **Relationship to Patient**: _____ **Birthday**: ____/____/____

SS Number: _____-_____-_____ **Insurance Company**: _____

Subscriber Number: _____ **Do you have prescription coverage? ☐ Yes ☐ No**

D. Emergency Contact (This contact should also be listed on your HIPAA below)

In the event of an emergency while you are in our office, who should we contact?

_____ _____
Name **Relationship**

_____ _____ _____ _____
Address **City** **ST** **Zip**

(_____)_____-_____ (_____)_____-_____ (____)_____-_____
Phone: Home **Phone: Cell** **Phone: Work**

E. Health Record Release Authorization (HIPAA)
Disclosures to Family & Friends: I authorize disclosures of my health/dental information, relevant to current treatment to:

Name & Relationship: _____ **☐ In Person ☐ By Phone**
Phone Number: _____

Name & Relationship: _____ **☐ In Person ☐ By Phone**
Phone Number: _____

Name & Relationship: _____ **☐ In Person ☐ By Phone**
Phone Number: _____

All-inclusive signature: _____ **Date:** ____/____/_____
If you want any of your health records released, this page MUST be signed.

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SLIDING FEE SCALE APPLICATION

If you have insurance and do not wish to apply for the sliding fee scale, please initial here: _____

Patient Name (Printed): _____ Date: ____ / ____ / _____

Date of Birth: ____ / ____ / _____ **Do you file taxes? ☐ Yes ☐ No**

How many in your household are dependent on this income? _____ (include yourself)

Please complete the following:

Name (Spouse): _____ ____ - ____ - _____ (SS#) ___ / ___ / _____ (Date of Birth)

Name (Child/Dependent): _____ ____ - ____ - _____ (SS#) ___ / ___ / _____ (Date of Birth)

Name (Child/Dependent): _____ ____ - ____ - _____ (SS#) ___ / ___ / _____ (Date of Birth)

Name (Child/Dependent): _____ ____ - ____ - _____ (SS#) ___ / ___ / _____ (Date of Birth)

Name (Child/Dependent): _____ ____ - ____ - _____ (SS#) ___ / ___ / _____ (Date of Birth)

Name (Child/Dependent): _____ ____ - ____ - _____ (SS#) ___ / ___ / _____ (Date of Birth)

How often do you get paid? ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Annually ☐ Does not apply

Please list your gross income for everyone in your household:

Salary Wages:	$_____	Social Security:	$_____
Interest on Savings Accounts:	$_____	Dividends on Investments:	$_____
Pension	$_____	Personal Business Profits:	$_____
Rental Income:	$_____	Disability:	$_____
Unemployment:	$_____	Alimony:	$_____
Veteran's Benefits:	$_____	Child Support:	$_____
Aid to Dependent Children:	$_____	SSI:	$_____
Other: _____	$_____	Other: _____	$_____

Total Annual Income: $_____

The information provided concerning the size of my family and my family's gross annual income from all sources is true, accurate, and complete to the best of my knowledge. I realize that PATHS Community Medical/Dental Center will rely on such information to determine how much my account will be discounted. I realize that knowingly giving false information in this case may result in criminal prosecution under the laws of Virginia. I agree to report any change in either my income or my family size to PATHS. PATHS may initiate a review of my payment status at any time to verify the information I have provided.

Signature: _____ Date: ____ / ____ / _____

For Front Desk Use Only:

Sliding Scale Type: _____ **Sliding Fee Scale Expiration Date**: ____ / ____ / _____ **Initial**: _____

PATIENT MEDICAL INFORMATION

Name: _____ Age: _____ DOB: _____
Weight: _____ Height: _____ Influenza Virus Given: ☐ Yes ☐ No If yes, date: _____

List Health Conditions:

Condition	Age of Diagnosis	Status

List Medications Currently Using:

Name	Strength	Frequency	Taken When?	Prescriber	Prescriber Phone #

Family History Information:

Mother	Father	Sibling	Child	Living	Deceased	List Medical Conditions They Have Or Have Had
		→				
→						

F. Patient Medical History

Primary Care Physician: _____ Phone: ( ) _____-_____ Date of Last Visit: ___/___/___

1. Are you currently under medical treatment for any condition? □ Yes □ No
2. Have you been hospitalized for any surgical operation or illness within the past 5 years? □ Yes □ No
3. Have you ever taken Fen-Phen/Redux? □ Yes □ No
4. Have you taken Fosamax, Boniva, Actonel, or any cancer medications containing bisphosphonates? □ Yes □ No
5. Have you taken Viagra, Revati, Cialis, or Levitra in the last 24 hours? □ Yes □ No
6. Do you use tobacco? □ Yes □ No If yes, □ Light smoker □ Heavy Smoker □ Ex-smoker When did you quit? _____
7. Do you use controlled substances? □ Yes □ No
8. Are you hearing impaired? □ Yes □ No
9. Are you vision impaired? □ Yes □ No
10. Do you have a persistent cough/throat clearing not associated with a known illness? □ Yes □ No
11. Are you allergic, or had reactions to any of the following:

□ Yes □ No Aspirin	□ Yes □ No Erythromycin	□ Yes □ No Percocet
□ Yes □ No Benzocaine	□ Yes □ No Fluoride	□ Yes □ No Prophy Paste
□ Yes □ No Cipro	□ Yes □ No Food	□ Yes □ No Seasonal Allergies
□ Yes □ No Clindamycin	□ Yes □ No Iodine	□ Yes □ No Sulfa
□ Yes □ No Codeine	□ Yes □ No Latex	□ Yes □ No Tetrocycline
□ Yes □ No Darvocet	□ Yes □ No Local Anesthetic	□ Yes □ No Tylenol
□ Yes □ No Epinephrine	□ Yes □ No Penicillin	□ Yes □ No Z-pak

12. Do you have, or had any of the following:

□ Yes □ No ADD/ADHD	□ Yes □ No Epilepsy/Seizures	□ Yes □ No Hormone Therapy
□ Yes □ No Anemia	□ Yes □ No Excessive Bleeding	□ Yes □ No Jaundice
□ Yes □ No Angina	□ Yes □ No Fibromyalgia	□ Yes □ No Kidney Disease
□ Yes □ No Arthritis	□ Yes □ No General Allergies	□ Yes □ No Liver Disease
□ Yes □ No Artificial Joints	□ Yes □ No Glaucoma	□ Yes □ No Lupus
□ Yes □ No Asthma (Use Inhaler)	□ Yes □ No Growths	□ Yes □ No Menopause
□ Yes □ No Back/Spine Injury	□ Yes □ No Hay Fever	□ Yes □ No Mental Disorder
□ Yes □ No Blood Disease	□ Yes □ No Heart Disease/Problem	□ Yes □ No Migraines
□ Yes □ No BPH/Prostate Health	□ Yes □ No Hepatitis	□ Yes □ No Mitral Valve Prolapse
□ Yes □ No Cancer (Kind?) _____	□ Yes □ No Herpes	□ Yes □ No Neurological Disorder
□ Yes □ No Diabetes	□ Yes □ No High Blood Pressure	□ Yes □ No Pregnancy
□ Yes □ No Dizziness/Fainting Spells	□ Yes □ No High Cholesterol	□ Yes □ No Stroke
□ Yes □ No Endometriosis	□ Yes □ No HIV	

WOMEN ONLY:

13. Are you pregnant, or think that you may be pregnant? □ Yes □ No If yes, anticipated due date? _____
14. Are you nursing? □ Yes □ No
15. Are you taking oral contraceptives? □ Yes □ No

I give the dentist and/or hygienist permission to use local anesthetic as needed: □ Yes □ No

By signing below, I certify that I have read and understand the above medical history questionnaire. I understand that this information will be used by PATHS Community Dental Center staff to help determine appropriate and healthful dental treatment. If there are any changes in my medical status, I will inform PATHS Community Dental Center immediately.

Patient/Guardian Printed Name: _____

Patient/Guardian Signature: _____ Date: _____

Community Dental Center
501 Rison Street, Suite 110
Danville, VA 24541
(P) 434-791-0214 (F) 434-791-0217

Dear Patient:

As a component of the clinical curriculum at Virginia Commonwealth University School of Dentistry, senior dental and dental hygiene students provide oral health care in the community under the supervision and direction of a licensed dentist appointed as an external affiliate instructor. The code of Virginia (Chapter 27, Title 54.1-2721) permits this practice.

To enhance the level of oral health care provided to you, the PATHS Community Dental Center has partnered with VCU I this educational opportunity. All procedures completed by the attending student will be evaluated by the supervising dentist. No procedure will be performed without your knowledge and consent.

Please give your permission to be treated by a senior dental student by signing the consent form below.

Sincerely,
PATHS Community Dental Center

Consent to Participate

I have read the above informed consent letter and agree to be treated by a senior dental and/or dental hygiene student under the supervision of a licensed dentist.

If you do not want to be treated by a senior student, please check here: ☐

_____	_____
Patient's Printed Name	Date of Birth
_____	_____
Patient's Signature	Date
_____	_____
Witness (printed/signature/title)	Date