BAY COUNTY
JUVENILE HOME

To Parent/Guardian or referring agency:

Your youth is a current resident at our facility. Attached are a few policies that are required to be shared with you.

Medical Consent: The BCJH contracts a registered nurse and licensed doctor to review resident medications and to handle minor medical issues. The BCJH is required to provide a physical within 7 days of placement unless there is a copy of a physical provided that had been completed in the last 10 months. The youth can request to see the nurse during medical clinic times. Please complete the medical consent form online so that we may attend to your youth's immediate medical needs. The nurse will contact the legal parent/guardian on file to discuss any changes in health status. If for any reason your youth needs to be transported to urgent care or the hospital you will be contacted as soon as possible.

Prescriptions: The staff understand that transportation to the BCJH may not always be convenient or possible. The BCJH utilizes Healthlink Pharmacy. You may choose to have refills transferred to Healthlink and let them know that the prescriptions need to be delivered to the Bay County Juvenile Home. You will need to provide insurance information and pay any co-pays.

Healthlink Pharmacy
322 Garfield Avenue
Bay City, MI 48708
989-391-9068

Immunizations: Immunization Clinic is the first Thursday of each month. The Bay County Health Department administers the immunizations at **no cost**. The registered nurse refers to the Official State of Michigan Immunization Record for each youth to determine the eligibility for immunizations. Immunizations available are Tdap, Hib, Polio, MMR, Hep B, Vericiella, Hep A, Flu, Pneumococcal Conjugate, Meningococcal Conjugate and HPV. Some of these vaccinations are a series. If the youth refuses the immunization we do not force the youth to receive them. The Health Department requires a consent form to be completed. Please see immunization consent form on the website. The BCJH is required to offer these immunizations for youth who remain in the facility after 29 days. If you have an up to date immunization record please fax or email to the BCJH. Fax # 989-892-4419 or email juvhome@baycounty.net. You may also give a copy of the record to the Probation Officer or DHHS caseworker to forward to the facility.

Dental: Dental services are provided to youth by My Community Dental Centers at 2614 Center Avenue Bay City, MI 48708. Please complete the dental consent form. If there are costs there will be no services completed unless the cost is approved by the legal parent/guardian or referring agency.

Thank you,

Bay County Juvenile Home

BAY COUNTY Phone: (989) 892-4519

Juvenile Home 520 West Hampton Road, Essexville, MI 48732

Visitation is limited to parents/legal guardians and grandparents listed in the residents file unless rights of the parent/legal guardian/grandparents have been terminated by the Court. Other visitors shall be prohibited unless approved by BCJH Administration in advance.

Phone visitations dates and times:
Wednesdays: 6:00pm to 7:30pm
Sundays: 3:00pm to 4:30pm

1. In person visits are scheduled for 30 minutes once a week with parent/guardian and/or grandparent. There will be a maximum of two visitors per visit.

2. If the parent/guardian has questions or concerns they may direct that to the Supervisor on duty or Team Leader. The parent/guardian may call back during business hours to speak with the Director or put concerns in writing.

3. Youth visitation may be suspended if the youth is a security threat to himself or others. This threat must be documented in the youth's file and communicated to the referring agency and parent/guardian.

4. Youth may refuse to visit with parent/legal guardian or grandparents without negative consequence. Any refusal and stated reason for refusal shall be documented in the youth's file. Staff shall contact the visitor of the youth's stated refusal if the refusal is known in advance.

5. All visitors are subject to a metal detector search upon entry to the facility. Purses, bags cell phones, tobacco products, food, drink or other personal items are prohibited. Visitors may be asked to take items back to their vehicle. Coats may be hung in the hallway. There is a locker in the entrance way to secure items while visiting.

6. Visitors shall have suitable identification upon request. Visitation may be denied without valid identification. All visitors must sign in when entering the facility.

7. Visitors are not to pass items to residents without review and approval from Bay County Juvenile Home (BCJH) staff. Passing of items to youth without the expressed permission of Juvenile Home employees is prohibited and will result in termination of visit. If the visit is terminated the reason for the termination must be documented in the youth's file.

8. All visits are monitored by BCJH staff.

9. Young children shall not be left unattended in the parking lot/vehicle while parents are visiting. Children are not allowed in the facility to visit with youth.

10. The visit may be terminated if deemed necessary by BCJH staff.

11. There is absolutely no smoking or use of tobacco products in the Juvenile Home or on the facility grounds by anyone. This is a State Law punishable by fines. This includes the use of any form of vape pen.

12. Type of visit
    a. Phone call: Youth may receive phone calls from approved legal guardians/parents and grandparents. Youth may make phone calls as long as they have privileges to approved legal guardians/parents and grandparents.
    b. In person: Residents may receive visits in the facility by approved legal guardians/parents and grandparents on visiting days, during approved visiting hours.

13. Termination of visit: The visit may be terminated if the visit is a detriment to the resident.
    a. The youth is crying and visibly upset and continuation of visit appears detrimental to youth. Arguing from parent or resident that is disruptive. Constant clinging and touching of resident/parent. Passing of any unauthorized item to the youth/parent.
    b. Telephone calls will be terminated if it is found the youth is speaking with an unauthorized person. The youth will then receive a point loss unless it is the youth who notifies staff that he/she has an unauthorized person on the line.
    c. Resident phone calls shall be terminated if the youth's behavior warrants a fine.

All visits that are terminated either by the visitor, youth or BCJH staff must be documented in the youth's file. The reason for the termination of the visit shall be documented whenever possible.

BAY COUNTY
JUVENILE HOME

Acknowledgement of Policy

Dear Parent/Guardian or Referring Agency:

It is required that the Bay County Juvenile Home provide each parent/guardian and/or referring agency with a copy of specific policies listed below. It is requested that you initial and sign below indicating that you have received each policy. All policies are available on the Juvenile Home website under "Policy Packet" or available upon request at the Juvenile Home. Please indicate the policies you have received by initialing next to each received policy below:

___ Program Statement

___Grievance Policy

___Religion Policy

___ Intervention Standards

___ Seclusion Policy

___ Mechanical Restraint

___ Emergency Restraint

___ Health Status Assessment

Your signature verifies that you have received a copy of the policies noted above. You understand that if you have questions or concerns you may speak with a Supervisor or the Director.

For further questions or concerns I may contact:

Supervisors Joe Beauchamp and Art Amador or Director Juli Reynolds

Signature: _____ Date: _____

Print name: _____

Youth's Name: _____

Relationship to youth: _____ **OR**

Representing Court/Agency: _____

Staff shall review the form to ensure it is filled out accurately and then

Attach this form into the Youth's file

Revised 8/8/24

520 West Hampton Road, Essexville, Michigan 48732
Tel: (989) 892-4519| Fax: (989) 892-4419 | TDD (hearing impaired): 989-895-4049
Web: www.baycounty-mi.gov

BAY COUNTY
JUVENILE HOME

MEDICAL CONSENT AND AUTHORIZATION FORM

Resident Name:	DOB:

I hereby consent and authorize: Bay County Juvenile Home
520 West Hampton Road, Essexville, MI 48732
Phone: 989-892-4519 Fax: 989-892-4419
Email: juvhome@baycounty.net
To provide the following services for my child:

Any physical examination and/or appropriate routine medical care or treatment including consent for hospital admittance, emergency treatment including surgery, dental care or mental health services to be provided by qualified medical personnel as deemed necessary to protect the health of my child. This consent and authorization includes the authorization for disclosure of my child's complete health records as may be necessary to provided appropriate medical care and treatment and follow-up care.
Initial _____

It is understood that the Bay County Juvenile Home will make all reasonable efforts to notify me of any injury or emergency medical care or treatment that is necessary while my child is in the care and custody of the Bay County Juvenile Home. I understand I have the right to revoke this authorization at any time prior to disclosure by giving written notice to the Facility Director. **Initial** _____

I consent to testing for infectious, contagious and sexually transmitted diseases including, but not limited to hepatitis, hepatitis B, HIV and AIDS in the event my child's bodily fluid comes into contact with any volunteer, employee or other youth of the BCJH. Results of that testing will be made available to the Director of the Bay County Juvenile Home.
Initial_____

Last dental appointment for youth:

Allergies for youth:

Medication Allergies:

Include reaction if ingested or exposed. What precautions are required by medical professional?

Food intolerance or allergy **If your youth has an intolerance to a food please note that it is a food intolerance versus an allergy.** Include reaction if ingested or exposed. What precautions are required by medical professional?
Other Allergies: Include reaction if ingested or exposed. What precautions are required?
Does the youth have prescribed medications for allergic reactions such as an EpiPen or other prescription? Did you bring this prescription to the facility to be available for the youth in the event of an allergic reaction?
Has this youth ever been diagnosed with Asthma? Yes or No Does the youth currently have a prescribed inhaler? If yes, was the inhaler provided to this facility while the youth is lodged? Will the youth have trouble breathing participating in physical activity without an inhaler? Indoors/outdoors
Does this youth have prescription glasses? Yes No Are those glasses available to the youth in while lodged? Yes No

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____

Please provide a copy of insurance card if available:

Refusal to Consent to Vaccination
Bay County Juvenile Home

The Bay County Juvenile Home as a Child Caring Institution is required to offer immunizations to youth every 30 days. The Bay County Health Department will provide immunizations to the youth at the Bay County Juvenile Home every first Thursday of the month unless scheduled otherwise. BCJH staff shall use this document when a parent or youth refuses any recommended vaccine. Place this completed form in the youth's file and provide to the Health Department Nurse who presents for the immunization clinic.

Youth's Name: _____ Youth's DOB: _____

Parent's/Guardian's Name(s): _____

The Bay County Juvenile Home and/or The Bay County Health Department have advised me that my child (named above) should receive the following vaccines:

Recommended	Vaccine	Declined	Reason for Refusal
	Diphtheria, tetanus, acellular pertussis (DTaP)		
	Diphtheria, tetanus (DT or Td)		
	Haemophilus influenzae type B (Hib)		
	Hepatitis A (Hep A)		
	Hepatitis B (Hep B)		
	Human papillomavirus (HPV)		
	Influenza		
	Measles, mumps, rubella (MMR)		
	Meningococcal (MCV or MPSV)		
	Pneumococcal vaccine (PCV or PPSV)		
	Polio (IPV)		
	Rotavirus (RV)		
	Tetanus, diphtheria, acellular pertussis (Tdap)		
	Varicella (chickenpox) (Var)		
	COVID 19		

I have read the Centers for Disease Control and Prevention's Vaccine Information Statement(s) explaining the vaccine(s) and the disease(s) they prevent (BCJH staff have the information available upon request or contact the Bay County Health Department 989(895-4009 option #2). I understand the following:

- The **purpose** of the recommended vaccination
- The **risks and benefits** of the recommended vaccination
- **Possible consequence(s)** of not allowing my child to receive the recommended vaccination may include contracting the illness the vaccine is intended to prevent and transmitting the disease to others
- The Bay County Health Department, the American Academy of Pediatrics, the American Academy of Family Physicians, the Centers for Disease Control and Prevention, and the Michigan Department of Health and Human Services **strongly recommend** that the vaccine(s) be given.

I may contact the The Bay County Health Department Immunization Clinic (989)895-4009 option #2 with any questions
I know that I may change my mind and accept vaccination for my child in the future by contacting the Bay County Juvenile Home or the Bay County Health Department and completing the consent forms.
I accept sole responsibility for any consequences as a result of my child not being vaccinated.
I acknowledge that I have read this document in its entirety and fully understand it.

_____ _____
Parent/Guardian Signature Date

_____ _____

Please note that this document is not a waiver form. A waiver form is a document that can be signed when you are exempting from vaccines that are required for school and childcare. Please see www.michigan.gov/immunize for more information on waiver

fill out both sides please

CLIENT CONSENT

Bay County HEALTH Department

1200 Washington Avenue
Bay City, Michigan 48708

Client Name:_____ File Number:_____

Any statement not agreed to may be crossed out and initialed by client or client's authorized representative.

CONSENT FOR CARE

I hereby voluntarily consent to authorized BCHD health care professionals including physicians, nurse practitioners, nurses, medical assistants, social workers, and employees of Bay County Health Department (BCHD) to perform services, procedures and/or treatments as prescribed by my physician or in accordance with BCHD specific program/clinic/service protocol.

I further authorize BCHD to obtain specimens of blood, urine, and other body fluids, tissues or products for the purpose of tests or procedures as deemed appropriate for my care. I realize that if tests are taken for sexually transmitted diseases, reporting positive test results to the Michigan Department of Health & Human services is required by law.

I authorize the use of photographs for the purpose of health care and documentation and transfer to BCHD all rights and interest in such photographs.

I have had the purpose of the program/service explained to me, want to participate, and have reviewed my plan of care (if applicable). I understand the services I am to receive, and understand I can withdraw from participation at any time.

CONSENT TO HIV TESTING

I understand that BCHD may perform an HIV, Hepatitis B and Hepatitis C test upon me without additional written consent in the event a BCHD health professional or designee has a percutaneous, mucous membrane, or open wound exposure to my blood or body fluids. The results of any test(s) will be treated confidentially, but may be disclosed as necessary for care of the health professional or designee at risk for blood borne pathogen infection due to exposure to my blood or body fluids

CONSENT to BILL

I request that payment of the authorized benefits from my health insurance be made on my behalf to BCHD. I certify that the Health insurance information I provided is accurate and correct. BCHD will accept payment from Medicare and Medicaid as full payment for covered services.

In the event the insurance company pays me directly, or if the service is not covered by my health insurance, I or my estate will be fully responsible for reimbursing BCHD.

☐ Services to be billed to my insurance
☐ Services to be billed to me

Bill: ☐ Medicare ☐ Medicaid ☐Blue Cross/Blue Shield ☐ Other Insurance
☐ Sliding Fee Scale

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION

I authorize BCHD to release by mail, phone, fax, or secure encrypted email and/or to obtain all or any portion of my or my child's health record to or from hospitals, health care providers, insurance companies, service agencies, auditors or others involved in my or my child's care that may be pertinent to the delivery, coordination and evaluation of my/my child's care. This includes all information about my or my child's status related to communicable diseases and infections, sexually transmitted infections (STI), Tuberculosis (TB), Hepatitis B, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), alcohol and drug abuse treatment information, mental health treatment records, psychological services and social services information including communications made by me to a social worker.

CONSENT & AUTHORIAZTON TO RELEASE MEDICAL INFORMATION TO OBTAIN PAYMENT

I authorize BCHD and its health care providers to release to any third party payor (Medicaid, Medicare, private health insurance etc.) and their clinical review agencies, or insurance carriers, welfare authority or other person or party responsible for any portion of care that is rendered to me such information from my health records as is required in order for BCHD to receive payment or reimbursement for my treatment, including alcohol, and drug abuse records protected under regulations in 42 Code of Federal Regulations, Part 2 (if any), psychological service records (if any), and social service records (if any). This consent shall be effective only so long as is necessary to obtain payment or retrospective authorization for payment and will expire when final payment has been received. This consent to release medical information is subject to revocation at any time with respect to any drug or alcohol abuse records, except to the extent the information has previously been release in reliance thereon.

This consent can be revoked by the client/client's authorized representative at any time unless the agency has acted in reliance upon its continued effectiveness. Without expressed revocation this consent expires within one year, or (please check) ☐ until no longer enrolled in Children's Special Health Care Services.

☐ **I have received a copy of the Bay County Notice of Privacy Practices**

I have read this consent form or it has been read to me and have had my questions answered to my satisfaction.

_____ _____ _____
Signature of Client or Authorized Representative | Relationship | Date

Reason for signature of Authorized Representative (instead of Client Signature):_____

_____ _____
Signature of BCHD Representative | Date

IM 07a
Revised 10-18

fill out both sides please

Bay County HEALTH Department

fill out both sides please

Last	First	M.	Age
Address	City	State MI	Zip
Phone #	Maiden Name	Birth Date / /	
Gender ☐ Male ☐ Female	Race ☐ Caucasian ☐ African American ☐ Hispanic ☐ Other	Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Other	

Insurance Type _____

Card Holder Name: _____ Card Holder Birth Date: _____

Enrollee ID _____ Group # _____

Medicare # _____ Medicaid # _____

1. **Are you allergic to eggs, thimerosal (preservative), latex, or have any other allergies?** ☐ Yes ☐ No
2. **Have you ever had an adverse reaction to a flu shot or any other vaccine?** ☐ Yes ☐ No
3. **Have you had Guillain-Barre syndrome within 6 weeks of a flu shot?** ☐ Yes ☐ No
4. **Are you sick today?** ☐ Yes ☐ No
5. **Have you had MMR, Varicella, Nasal Spray Flu or any other vaccines in the past 30 days?** ☐ Yes ☐ No
6. **Have you ever had a seizure or neurological problem?** ☐ Yes ☐ No
7. **Have you taken cortisone, prednisone, steroids, anticancer drugs, or x-ray in last 3 months?** ☐ Yes ☐ No
8. **Have you received a blood transfusion, plasma, or immune globulin in the last year?** ☐ Yes ☐ No
9. **Are you pregnant or is there a chance of becoming pregnant the next 3 months?** ☐ Yes ☐ No
10. **Do you have cancer, leukemia, AIDS, or any other immune system problem?** ☐ Yes ☐ No
11. **Did you receive the vaccine information sheet today?** ☐ Yes ☐ No
12. **Do you have any questions?** ☐ Yes ☐ No

MCIR (Michigan Care Improvement Registry)

fill out both sides please

☐ **Yes, please register my or my child's immunization history in the MCIR system.**

☐ **No, I do not want my or my child's immunization history registered in the MCIR system.**

SIGNATURE _____ **Legal Guardian Name:** _____

For Office Use Only

☐CPOX	Lot # _____	Site _____	Manuf. _____	Eligibility $ or VFC or AVP
☐DTAP	Lot # _____	Site _____	Manuf. _____	Eligibility $ or VFC or AVP
☐FLU	Lot # _____	Site _____	Manuf. _____	Eligibility $ or VFC or AVP
☐HEP A	Lot # _____	Site _____	Manuf. _____	Eligibility $ or VFC or AVP
☐HEP B	Lot # _____	Site _____	Manuf. _____	Eligibility $ or VFC or AVP
☐HIB	Lot # _____	Site _____	Manuf. _____	Eligibility $ or VFC or AVP
☐HPV	Lot # _____	Site _____	Manuf. _____	Eligibility $ or VFC or AVP
☐KINRIX	Lot # _____	Site _____	Manuf. _____	Eligibility $ or VFC or AVP
☐MENACWY	Lot # _____	Site _____	Manuf. _____	Eligibility $ or VFC or AVP
☐MEN B	Lot # _____	Site _____	Manuf. _____	Eligibility $ or VFC or AVP
☐MMR	Lot # _____	Site _____	Manuf. _____	Eligibility $ or VFC or AVP
☐MMRV	Lot # _____	Site _____	Manuf. _____	Eligibility $ or VFC or AVP
☐PCV13	Lot # _____	Site _____	Manuf. _____	Eligibility $ or VFC or AVP
☐PEDIARIX	Lot # _____	Site _____	Manuf. _____	Eligibility $ or VFC or AVP
☐PPSV23	Lot # _____	Site _____	Manuf. _____	Eligibility $ or VFC or AVP
☐POLIO	Lot # _____	Site _____	Manuf. _____	Eligibility $ or VFC or AVP
☐ROTA	Lot # _____	Site _____	Manuf. _____	Eligibility $ or VFC or AVP
☐SHINGRIX	Lot # _____	Site _____	Manuf. _____	Eligibility $ or VFC or AVP
☐TDAP	Lot # _____	Site _____	Manuf. _____	Eligibility $ or VFC or AVP

Nurse Signature _____

My Community Dental Centers

Chart #:

SUBSTITUTE AUTHORIZATION (MINOR CHILD)

Date: _____

Patient Name: _____ Patient DOB: _____

I, _____, as parent/legal custodian of the above named minor child, hereby authorize the following individual(s) listed to attend my child's appointment at MCDC in my absence, consent to any treatment based on the current treatment plan, and communicate with the staff at MCDC regarding my child's care. This includes the authority to receive any and all confidential/protected health information* in the possession of MCDC as required for coordination of care, without violation of any applicable Federal or state laws. I understand that any substitute must be 18 years of age or older, and I agree to inform my substitute to provide photo I.D. to MCDC staff at the time of the appointment.

Name of Individual(s)	Relationship to Child
_____	_____
_____	_____
_____	_____

* "Confidential health information" means information concerning the patient made confidential or protected by Federal law.

IMPORTANT NOTICE: If my child attends the appointment alone or with an individual not authorized by this document, I understand that MCDC has the right not to treat my child at that time and to reschedule the appointment.

Revocation: Except as otherwise provided by law, I may revoke this Authorization by notifying MCDC in writing, or effective as of a date certain if noted below.

_____ Valid until revoked in writing
_____ Authorization to expire on ____/____/____

A COPY OF THIS AUTHORIZATION SHALL BE DEEMED AS VALID AS THE ORIGINAL

_____ _____

Parent/Legal Custodian Signature Parent/Legal Custodian Printed Name

My Community Dental Centers

Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Birth Date: _____ Gender: __ Family Status: _____

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

Address: _____
Street Apartment #

_____
City State Zip Code

Preferred appointment reminder: ☐ Voice Message ☐ Text Message ☐ Email

Emergency Contact Person: _____ Relation to Patient: _____

Phone Number: _____

Health Information

Please Note: All of the following information is needed to allow us to treat you safely and will be kept CONFIDENTIAL.

Please check where you receive your medical care:

☐ Doctor's Office_____ Primary Care Provider:_____ ☐ Urgent Care/Emergency Room ☐ FQHC

PLEASE CHECK ALL THAT APPLY:

MEDICAL HISTORY

- ☐ ADD/ ADHD
- ☐ AIDS/HIV+
- ☐ Alcoholism
- ☐ Alzheimer's Disease
- ☐ Aortic Stenosis
- ☐ Arthritis/Osteoarthritis
- ☐ Asthma
- ☐ Auto-immune Disease
  - ☐ Rheumatoid
  - ☐ Fibromyalgia
  - ☐ Lupus
- ☐ Blood Disorder: _____
- ☐ Cancer:_____
  - ☐ Chemotherapy
  - ☐ Radiation
- ☐ Cataracts
- ☐ Cleft Palate
- ☐ Concussion / Head Injury
- ☐ COPD / Emphysema
- ☐ Dementia
- ☐ Depression
- ☐ Developmental Disabilities
- ☐ Diabetes
  - ☐ Stasis Ulcers
  - ☐ Hypoglycemia
- ☐ Eating Disorders
  - ☐ Anorexia
  - ☐ Bulimia
- ☐ Epilepsy / Seizures
- ☐ Gastro-intestinal Disorders
  - ☐ Heartburn / Indigestion
  - ☐ Ulcers
- ☐ Heart Disease
  - ☐ Heart Attack:_____
  - ☐ Heart Failure
- ☐ Hepatitis / Liver Disease
- ☐ High Blood Pressure / HTN
- ☐ Kidney Disease
- ☐ Mitral Valve Prolapse
- ☐ Multiple Sclerosis
- ☐ Postural Hypotension
- ☐ Pregnancy –Due Date:_____
- ☐ Psychiatric Disorders
- ☐ Sleep Disorders
  - ☐ CPAP
- ☐ Stroke / CVA: _____
  - ☐ Paralysis L- R
  - ☐ Weakness L- R
  - ☐ Aphasia
- ☐ Thyroid Disorders
- ☐ Tuberculosis
- ☐ Venereal Disease / STD

COMMON SYMPTOMS

- ☐ Abnormal Heart Beat / Arrhythmia
- ☐ Angina / Chest Pain
- ☐ Anxiety
- ☐ Bruise Easily
- ☐ Chronic Back Pain
- ☐ Chronic Hoarseness / Cough
- ☐ Constipation
- ☐ Difficulty Swallowing/ Dry Mouth
- ☐ Dizziness
- ☐ Fainting
- ☐ Forgetfulness / Memory Loss
- ☐ Hives / Eczema
- ☐ Increased Thirst
- ☐ Migraines / Headaches
- ☐ Nausea / Vomiting
- ☐ Neuritis / Neuralgia / Sciatica
- ☐ Recent-Dramatic Weight Loss
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Swelling of Hands /Feet

SURGICAL HISTORY

- ☐ Artificial Joints:_____
- ☐ Heart Surgery: _____
  - ☐ Artificial Valve
  - ☐ Heart Murmur
  - ☐ Coronary Artery Bypass
- ☐ Implantable Cardiac Defibrillator
- ☐ Pacemaker
- ☐ Other Surgery:_____

Please place other health related issues you may be experiencing here:

_____

_____

_____

My Community Dental Centers

MEDICATION SPECIFIC QUESTIONS

- Have you ever taken any of the following medications for Osteoporosis, Bone Cancer or Osteoarthritis?
  - ☐ Alendronate (Fosamax) Pamidronate (Aredia)
  - ☐ Alendronate & Cholecalciferal (Fosamax Plus)
  - ☐ Clondronate (Bonefes, Clasteon)
  - ☐ Etidronate & Calcium (Calcium Carbonate, Didrocal)
  - ☐ Etidronate Disodium (Didronel)
  - ☐ Ibandronate (Boniva)
  - ☐ Pamidronate (Aredia)
  - ☐ Risedronate (Actonel)
  - ☐ Ridedronate & Calcium (Actonel & Calcium)
  - ☐ Tiludronate (Skelid)
  - ☐ Xgeva (Denosumab)
  - ☐ Zoledronic Acid (Reclast, Zometa)
  - ☐ Any Other Bisphosphonate Medication:_____
- Have you ever taken the prescription drugs Flenfluramine, Flenfluramine with Phentermine (fen-phen), dexfenfluramine (Redux or Pondimin) or other weight loss products? ☐ No ☐ Yes If so, When:_____ Did you have a follow up Echocardiogram: ☐ No ☐ Yes
- Are you or have you ever taken a Blood Thinning Medication such as Coumadin/Warfarin, Pradaxa, Plavix, Aspirin or Other? ☐ No ☐ Yes
- Have You Been on Steroid Therapy in the Last 6 Months? ☐ No ☐ Yes If so, when:_____ Name of Drug: _____

PLEASE LIST ALL CURRENT MEDICATIONS (DOSAGE AND TIME YOU TAKE THEM)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

PLEASE LIST ALL KNOWN ALLERGIES

☐ Penicillin ☐ Sulfa ☐ Aspirin ☐ Codeine ☐ Morphine ☐ Erythromycin ☐ Latex

Other Drug Allergies:_____

PERSONAL HEALTH HABITS

- Do you use tobacco products? ☐ No ☐ Yes Have you tried to quit? ☐ No ☐ Yes Do you want to know about quitting? ☐ No ☐ Yes
  ☐ Cigarettes ☐ Cigars ☐ Chewing Tobacco ☐ Snuff If so, How long have you used? _____ How much do you use each day?_____
- Do you drink alcohol? ☐ No ☐ Yes ☐ Beer ☐ Liquor ☐ Wine ☐ Other
  How long have you drank alcohol? _____ How often do you drink alcohol? _____ Do you think you drink too much? ☐ No ☐ Yes
- Do you drink any of the following beverages? ☐ No ☐ Yes ☐ Coffee ☐ Pop (Diet/Reg) ☐ Tea If so, How often? _____
- Do you use recreational/street drugs? ☐ No ☐ Yes If so, what:_____ How often: _____ How long:_____

  When Did You Last Use?_____ **(It is very important that you are honest about this because it can affect your treatment.)**

IMPORTANT ADDITIONAL INFORMATION

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ No ☐ Yes
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ No ☐ Yes
  If yes, please explain:_____ Name of Physician: _____
- Do you have any health problems that need further clarification? ☐ No ☐ Yes
  If yes, please explain:_____

_____ ___/___/____
PATIENT (PARENT/GUARDIAN) SIGNATURE DATE

_____ ___/___/____
DDS SIGNATURE DATE

My Community Dental Centers

Adult Dental History

Purpose of your Visit: _____

Are you aware of a problem? _____

How long since your last _____

- Do you clench or grind your t… ☐ …es
- Have your ever experienced any pa… …s in the muscles of your face Or around your ear or jaw click or pop? ☐ Yes
- Are any of your teeth sensitive? ☐ No ☐ Yes
- Do your gums bleed or hurt? ☐ No ☐ Yes
- Are you pleased with the appearance of your teeth? ☐ No ☐ Yes
- Have you ever had gum treatment or surgery? ☐ No ☐ Yes
- Have you had any orthodontic treatment? ☐ No ☐ Yes
- Do you have a dental prosthesis (partial… …denture)? ☐ Yes

  If YES when was it made? Mont… Year _____
- Are you interested in getting… …s? ☐ No
- Have you had an unple… …experience or is there anything about dentistry that your stron… …e? ☐ No ☐ …
- Have you ever had to be pre-medicated with antibiotics or sedatives before dental treatment? ☐ No ☐ Yes

Please sign below

Child/Teen Dental History

- Is this your child's first visit to the dentist? ☐ No ☐ Yes
- If not, how long since their last visit? _____
- How often does your child brush their teeth? _____
- Does your child suck his/her thumb or fingers? ☐ No ☐ Yes
- Have there been injuries to teeth from falls or blows that could cause chips? ☐ No ☐ Yes
- Has your child had any problem with dental treatment in the past? ☐ No ☐ Yes
- Do you or your child think there is anything wrong with his/her teeth? ☐ No ☐ Yes

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

_____ ___/___/___
PATIENT (PARENT/GUARDIAN) SIGNATURE DATE

_____ ___/___/___
DDS SIGNATURE DATE

My Community Dental Centers

WELCOME TO MCDC

We are honored you have made an appointment with us for yourself, your child, or a person in your care, and for allowing us to provide your dental care. Our goal is to provide quality services and continually strive to improve our patients' experiences. You may receive a phone call from Press Ganey which is an outside survey company that we have partnered with to receive your valuable input.

APPOINTMENT REMINDER

MCDC provides a courtesy reminder for reserved appointments approximately one week prior to the appointment, as well as 1-2 days in advance. Appointment reminders may be sent by voice message, text message, or email. If you have any questions about these notifications, please call the center directly. **We may require a confirmation response from you that you will be in attendance for your reserved appointment.** If we do not receive a confirmation of your appointment, or we are unable to reach you, your appointment may be cancelled. Please be sure that the contact information we have on file for you is current and accurate at all times to avoid missing your courtesy reminder. If we are unable to reach you, your appointment may be cancelled.

BROKEN APPOINTMENT/CANCELLATION POLICY

Regular dental visits every 6 months, including examinations, cleanings, fluoride treatments, dental sealants, and fillings are important to keep teeth healthy. It is especially important that you keep your appointment! Valuable time has been reserved for you, or your child's care. A missed appointment results in lost time which could be used for another patient waiting to receive treatment.

If you fail to show for a reserved appointment, any appointments you have scheduled will be cancelled. We require 24 hour notice when canceling or rescheduling an appointment that has been reserved for you. Any combination of failing to give adequate cancellation notice, or not showing up for an appointment, may result in **DISMISSAL** from **all MCDC** center locations.

EMERGENCY CARE

Patients who have been dismissed from the center for either broken appointments, or cancellation reasons, will be notified by certified letter and will be seen for EMERGENCY care only for 30 days from the date of the dismissal letter.

MINOR PATIENT APPOINTMENTS

MCDC providers are required to discuss and obtain permission BEFORE providing treatment to all minor patients. (Children under the age of 18) An adult MUST be present in the center throughout the duration of the child's appointment. IF a parent is unable to bring the child to the appointment, there is a consent form that can be signed to authorize another adult permission to approve treatment plan procedures. Please request this form in advance of the reserved appointment.

HOME CARE

It is important to maintain regular 6 month checkup appointments, as well as maintain excellent home care and proper diet. If you **do not** keep on a regular 6 month schedule, maintain excellent home care and proper diet, MCDC **cannot** be held responsible if restorative care fails. Failure of the restoration due to neglect of oral hygiene and a high sugar/high carbohydrate diet is the responsibility of the patient and not the dentist. Failure of any restoration within a two year time period, and the required follow up repair or extraction will be at the patient's expense. I understand and consent to having restorations completed with these guidelines.

My Community Dental Centers

SMOKE FREE CAMPUS

In order to maintain a safe and healthy work environment, MCDC is a smoke free campus. This means that employees, patients, and vendors are prohibited from smoking on the grounds or within sight of any MCDC building. Smoking is defined as the "act of lighting, smoking, or carrying a lighted or smoldering cigar, cigarette, e-cigarette, or pipe of any kind".

BEHAVIOR

Seeking and receiving medical care can be stressful and anxiety provoking. For the sake of all individuals involved, civil behavior with proper respect, courtesy and manners must be maintained and observed. There is also a zero tolerance for alcohol, drugs, smoking, or weapons on MCDC property. Individuals who use foul language, display threatening or violent behavior, or do not comply with our zero tolerance policy, will be immediately dismissed from all MCDC centers. In an effort to better serve you, cell phone use is not allowed beyond the reception area.

NOTICE OF PRIVACY

MCDC respects my right to privacy and confidentiality of my personal health information. I acknowledge that I have been informed of and offered a copy of the *Notice of Privacy Practices.*

CONSENT TO TREATMENT

I have read the above policy and agree to abide by it.

I HEREBY GIVE CONSENT TO My Community Dental Centers to provide treatment to:

_____, (check one) ◯ myself, ◯ my child, ◯ my ward, those procedures and treatments, including local anesthesia, which are deemed necessary. I consent to any x-ray, examination, anesthetic, sedative, or dental treatment rendered under the general, direct or indirect supervision of the dentist and his/her associates and/or staff members, as he/she may deem necessary.
Information about your appointment may be shared with your medical provider.
This authorization will remain in effect until canceled in writing by me.

I have read the above policy and agree to abide by it.