Rehoboth Life Care Ministries, Inc.
Dental Health Questionnaire/ Cuestionario Dental Sobre Su Salud
Have You Ever Had or Now Have/ Tiene o Alguna Vez a Tenido

Patient Name/ Nombre: _____ **Date/ Fecha: _____**

CHECK EACK ITEM/ REVISE CADA PUNTO	Yes/Si	No	CHECK EACH ITEM/REVISE CADA PUNTO	Yes/Si	No
AIDS/ SIDA			Hemophilia/Hemofilia		
Alcoholism/ Alcoholismo			Hepatitis A (Infectious)		
Allergies (Medicines) /Alergias(Medicinas)			Hepatitis B		
Allergies (Dust/Pollen) Alergias a polvo/ polen			Hepatitis C		
Alzheimer's Disease			Herpes/Herpes		
Anemia/ Anemia			High Blood Pressure/ Alta Presión Arterial		
Angina (Chest Pain)/ Dolor de Pecho			High Cholesterol/colesterol alto		
Arthritis/ Artritis			Hives (rash)/ Urticaria		
Artificial Heart Valve/ Válvula Artificial de Corazón			HIV Positive/ VIH Positive		
Artificial Joint/ Coyunturas Artificial			Hypoglycemia/Azúcar baja		
Asthma/Asma			Jaundice/ Ictericia		
Blood Disease/ Enfermedad de Sangre			Joint pain/ Dolor de coyuntura		
Breathing Problems/ Enfermedad Respiratoria			Kidney Problems/ Problema de los Riñones		
Bruise Easily/Moretón o Sangrado Fácil			Leukemia/Leucemia		
Cancer/ Cancer			Liver Disease/ Problema de Hígado		
Chemotherapy/ quimioterapia			Low Blood Pressure/ Baja Presión Arterial		
Chest Pain/ Dolor de Pecho			Lung Disease/Problema de los Pulmones		
Cold Sores/Fuegos (Herpes)			Mitral Valve Prolapse/Prolapso de Válvula Mitral		
Congenital Heart Disease/Lesion Congenial Corazon			Nausea & vomiting/ Nausea y vómitos		
Cough/ Tos			Nervousness/ Nerviosismo		
COPD / Enfermedad obstructiva de pulmones			Pain in Jaw Joints/ Dolor en las Coyunturas		
Diabetes/Diabetes			Psychiatric Care/ Cuidado psiquiátrico		
Diarrhea/ Diarrea			Recent Weight Loss/ Cambio de peso		
Dizziness/ Mareos			Reflux/ GERD / Reflujo		
Drug Addiction/ Adicción a las droga			Renal Dialysis/ diálisis de los riñones		
Ear, nose and Throat Problems/ Problemas de los oídos, nariz, o garganta			Rheumatic Fever*/Fiebre Reumática		
Emphysema/Enfisema			Rheumatism/ Reumatismo		
Epilepsy/Ataques Epiléptico			Seizures/ Epilepsia		
Excessive Bleeding/			Scarlet Fever/ Fiebre escarlatina		
Fainting/Desmayos			Shortness of Breath/ Falta de respiración		
Fever Blisters/ Ampollas			Sickle Cell Disease/Células Falciformes		
Frequent Cough/ Tos Persistente			Sinus Trouble/ Problemas de Sinusitis		
Frequent Diarrhea/Diarrea Frecuente			Skin Disease/ Problema de la piel		
Glaucoma/Glaucoma			Stomach/Intestinal Pain/ Dolores de estómago		
Hay Fever/Fiebre de Heno			Stroke/Derrame Cerebral		
Headaches/ Dolor de Cabeza			Swallowing difficulty/ Dificultad tragando		
Heart Surgery/ Cirugía de Corazon			Swelling of Limbs/ Hinchazón de los pies		
Heart Attack/ Ataque de Corazon			Thyroid Disease/ Enfermedad de Tiroides		
Heart Failure/Fracaso de Corazon			Tobacco Use/ Uso de Tabaco		
Heart Murmur/Sople de Corazón			Tuberculosis/Tuberculosis		
Heart Pacemaker/ Marco Paso de Corazón			Ulcers/ Ulceras		
Heart Disease/ Enfermedad de Corazón			Venereal Disease/ Enfermedad Sexuales		

Rehoboth
LIFE CARE MINISTRIES INC.
Dental Clinic
3208 U.S. Highway 41N. Byron, GA 31008
Phone: 478-953-7770 * Fax: 478-953-7771 * www.careforlifeclinic.com

Patient Name/ *Nombre*: _____
Date of Birth/*Fecha de Nacimiento*: _____

Name & Location of pharmacy/ Nombre de su farmacia: _____
Phone/ Teléfono#: _____

List of Allergies/ Alergias:_____

_____

Please bring an updated list of medications that you take at every visit.

Name of Medication *Nombre de su medicina*	Dosage *Cantidad*	How long have you been *Cuantas veces diaria*	Reason for taking this medication? *Razon por tomar esta medicina?*

English

Receipt of Notice of Privacy Practice
Written Acknowledgement Form

I have had the opportunity to review a copy of Rehoboth Life Care Ministries, Inc. **Notice of Privacy Practice.**

_____	_____
Patient's Name	Relationship to Patient
_____	_____
Signature	Date

Español

Recibo de Notificación de la Practica de Privacidad
Reconocimiento por Escrito

Yo he tenido la oportunidad de repasar una copia de la **Notificación de la Practica de Privacidad de la clínica Rehoboth.**

_____	_____
Nombre del Paciente	Parentesco con el Paciente
_____	_____
Firma	Fecha

Demographic Information - English

Last Name:_____ First Name :_____ Middle Name: _____

Date of Birth : (_____/_____/_____) Social Security: _____-_____-_____ Sex: Male ☐ Female ☐

Mailing Address _____ City: _____ State: ____ Zip Code: _____

County: _____ Email address_____

Home Phone: _____ Cell number: _____ Work number: _____

Number where we can leave you a message? _____Marital Status: M __ S __ D __ W__

Race: White __ Black __ Hispanic __ American Indian __ Asian __ Indian __ Other _____

Migrant Worker : ___ Not a farm worker____ Temporary worker ___ Not Homeless ___ Homeless ____ Public Housing ___

Live with another family ___ Live in a shelter ___ Live on the Streets/Car ___ Live in a transitional home ___

Veteran? _____ Language Barrier? _____

Employer's Name_____ Retired _____Yes _____ No

Full time student ____ Part-time Student____ (Name of School) _____

Información Demográfica - Español

Apellido: _____ Primer Nombre: _____ Segundo Nombre: _____

Fecha de Nacimiento (MM/DD/AAAA): (_____/____/____) Número de Seguro Social _____- ____- _____ Sexo: M ☐ F ☐

Dirección_____

Ciudad: _____ Estado: _____ Código Postal: _____ Condado: _____

Teléfono de Casa: _____ Celular: _____ Trabajo: _____

Correo Electrónico: _____ Donde podemos dejarle un mensaje? _____

Estado Civil (Marque uno): ___Soltero(S) __ Casado(M) __ Divorciado(D) __Viudo(W) __ Otro(O)

Raza(Marque uno): ___ Guero (W) ___Negro (B) ___Hispano(H) ___ Asiático(A) ___Indio (I) Otra raza: _____

Trabajador Migrante ___ No es campesino ___ Trabajo Temporario ___ Tiene Hogar__ Vive en la calle/carro___ Vive en casa del gobierno ___ Vive con otra familia __ Vive en refugio___ Vive en la calle/carro___ Vive en hogar transitorio/temporario___

Como oyó de nuestro servicios? _____ Necesita Interprete? _____ Retirado? _____

Ocupación: _____ Lugar de empleo: _____

Eres estúdiate? _____ Nombre de la escuela? _____

Rehoboth Life Care Ministries, Inc.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Rehoboth Life Care Ministries, Inc. to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

(The Notice of Privacy Practices provided by Rehoboth Life Care Ministries, Inc. describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent.
Rehoboth Life Care Ministries, Inc. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Rehoboth Life Care Ministries, Inc. privacy officer 3208 U.S Highway 42 N. Byron, Ga. 31008

With this consent Rehoboth Life Care Ministries, Inc. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Rehoboth Life Care Ministries, Inc. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Rehoboth Life Care Ministries, Inc. may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Rehoboth Life Care Ministries, Inc. restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Rehoboth Life Care Ministries, Inc. to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Rehoboth Life Care Ministries, Inc. may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian, if applicable

Rehoboth Life Care Ministry (RLCM)

CONSENT FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

RLCM and its staff may talk to the following individuals regarding my condition or course of treatment:

1. Name: _____Relationship: _____

Phone:_____

_____

2. Name: _____ Relationship: _____

Phone:_____

RLCM may leave a message (such as your scheduled appointment day & time) to me to the following phone number(s):

_____

_____

Do Not share my personal information with: _____

_____

In case of an Emergency contact:

Name: _____

Telephone: _____

_____ _____

PATIENT SIGNATURE (LEGAL GURADIAN) DATE

By signing above, you hereby consent for RLCM Volunteer Dental Clinic to use or disclose information about yourself (patient) that is protected under federal law. You may refuse to sign this consent form.