Community Health

Ellensburg Dental

Registrations forms may be dropped off at Yakima Pediatrics or emailed to dental.reception@chcw.org or fax to (509) 933-4804.

Please be sure to:

- **Complete full registration (everything must be filled out in order to register)**
- **Attach a copy of your ID and patients Insurance Cards**

Please attach all documents and turn them in together.

Thank you,
Ellensburg Dental

Community Health of Central Washington

Patient Registration Form

Patient's Information

Patient's Name: _____ DOB: _____ Medical Record #: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Physical Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
SSN #: _____ Gender: _____ Email Address: _____
Patient's Marital Status: _____ □ Single □ Married □ Divorced □ Widow □ Separated
Patient's Work Status: □ Full Time □ Part Time □ Not Employed □ Self Employed □Student
□ Military □ Retired

If currently working – Employer Name: _____ Phone: _____

Guarantor's Information

Name: _____ DOB: _____ Gender: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Home Phone _____ Cell Phone: _____ Work Phone: _____

Family Members

Patient's Name:_____Gender _____ DOB:_____ Relationship:_____
Patient's Name:_____Gender _____ DOB:_____ Relationship:_____
Patient's Name:_____Gender _____ DOB:_____ Relationship:_____
Patient's Name:_____Gender _____ DOB:_____ Relationship:_____

Insurance Information

Primary Insurance Name: _____
Primary Insurance ID#: _____Primary Insurance Group #: _____
Subscribers Name: _____
Subscribers DOB: _____Subscribers Gender: Male or Female (circle one)
Subscribers Address: _____ City: _____ State: _____ Zip: _____

Secondary Insurance Name: _____
Secondary Insurance ID#: _____Secondary Insurance Group #:_____
Subscribers Name: _____
Subscribers DOB:_____ Subscribers Gender: Male or Female (circle one)
Subscribers Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact

Name: _____ Phone: _____ Relationship: _____

Interpreter needed? (Check one) □ Yes □ No _____
Assistance Needed with reading or writing? (Check one) □ Yes □ No _____
If 18 years or older, is the patient a Veteran? (Check one) □ Yes □ No _____

Patient's Name: _____ DOB: _____ Medical Record #: _____

We appreciate that you selected us as your health care provider. We provide services to people with insurance, those with not enough insurance, and those without health insurance. Our clinic receives funding from the government that requires we collect and report information about our patient population; therefore, we need you to answer the following questions:

How many people live in your household? _____
What is your current household monthly income? **(See chart below)** _____ **= Yearly Income**

Mark on the line where your household monthly income would be

$----------$7500 and over

$500 $1,000 $2,000 $3,000 $4,000 $5,000 $6,000 $7000

What is your preferred primary language? _____
Is the patient Hispanic? (Check one) □ Yes □ No

Which of the following group(s) does the patient belong to? (Check only one)

□ Black/African American □ Asian □ American Indian/Alaska Native
□ Native Hawaiian □ Other Pacific Islander □ White
□ More than one race □ Refused to Report/Unreported

If over 13 years old

Gender Identity: □ Male □ Female □ Transgender Male/Female-to-Male □ Transgender Female/Male-to-Female □ Other □ Choose not to disclose

Sexual Orientation:

□ Straight (not lesbian or gay) □ Lesbian or gay □ Bisexual □ Something else □ Don't Know □ Choose not to disclose

Experience with Agriculture (Farm-Work)

1. In the past 2 years have you or anyone in your family worked in any type of agriculture (farm work) like preparing, irrigating, or spraying the fields, nurseries, orchards: planting , picking, sorting, packing or transporting fruits, vegetables, grains, nuts, plants, tobacco, hops, flowers, grass, alfalfa, hay or other agricultural products; planting trees: working with Christmas trees; picking pine needles or Spanish moss; taking care of chickens, ducks, turkeys, cows, goats, sheep, fish, clams etc. or doing any other types of farm work, etc. _____Yes _____No

2. In the last 2 years, have you or a member of your family lived away from home in order to work in any type of agriculture (farm work)?_____Yes _____No

3. Have you or a member of your family stopped migrating to work in agriculture (farm work) because of disability or age (too old to do the work)? _____Yes _____No

For office use only : (YES to #1 and #2 = **Migrant)** (YES to #1 and NO to #2 = **Seasonal)** (YES to #3= **Aged/Disabled)** (NO to all three = **Non-farmworker)**

Patient's current living situation:

□ Own/Rent house or apartment (non-homeless) □ In between Housing □ Homeless
□ Halfway House/Transitional Housing □ Homeless Shelter

Community Health
of Central Washington

Patient's Name: _____ DOB: _____ Medical Record #: _____

AUTHORIZATION AND CONSENT

Authorization and Consent

- I consent that I am presenting at a clinic of Community Health of Central Washington for examination, diagnosis and /or treatment of my health, medical or dental condition.
- I give consent and authorize my provider/clinician(s) or his or her designees to order and/or perform all exams, tests, procedures and any other care deemed necessary or advisable for the diagnosis and treatment of my health, medical or dental condition.
- This consent is valid for each visit I make to a clinic of Community Health of Central Washington unless revoked by me in writing.
- I authorize and request my insurance company to pay directly to Community Health of Central Washington benefits otherwise payable to me.
- I understand that my medical and/or dental insurance carrier may pay less than the actual bill for services and that I am financially responsible for all charges for services rendered to me or my dependents, including the balance remaining after payment of possible insurance benefits, deductibles and applicable co-payments.
- I have received, reviewed and understand the Patient's Rights and Responsibilities
- I have received the Notice of Privacy Practices:

Signature
Patient/Parent/Guardian _____

Date: _____

Community Health of Central Washington

Patient's Name: _____ DOB: _____ Medical Record #: _____

PATIENT RESPONSIBILITIES- APPOINTMENTS

We appreciate your decision to receive dental treatment at Ellensburg Dental Care. To assist you in the process of receiving quality care and excellent service, we advise you of the following matters:

- Our staff appreciates that all patients, on the day of your scheduled appointment, to please arrive ***15 minutes*** early in order to fill out or update any necessary paperwork (consent forms, medical history, etc.) and verify current information.

- A patient is tardy to their appointment if he or she arrives more than **10 minutes** after their scheduled appointment time. If a patient is tardy, that appointment will be cancelled, and you will need to reschedule for another appointment.

- Please bring your current insurance information. You will also be asked to provide your current photo ID.

- If your first appointment is missed (new patient exam) you will be dismissed from our dental clinic for **1 calendar year**.

- Any patient that has **two** (2) No Shows or **two** (2) appointment cancellations with less than 24-hour notice within a six-month period will be dismissed from our dental clinic for six months (6) from the date of your second missed appointment. This step is necessary due to the high volume of individuals seeking dental care. Your understanding in this matter is greatly appreciated.

I have read and understand the responsibilities of being a patient at Ellensburg Dental Care.

_____ _____

Patient/Parent or Guardian Signature **Date**

Community Health
of Central Washington

Patient's Name: _____ DOB: _____ Medical Record #: _____

PATIENT RESPONSIBILITES- PAYMENTS

Effective April 13, 2015 patient financial guidelines are provided below:

1. **Private Pay:** Private pay patients will be responsible to pay for all services prior to treatment. Also, patients must have made all efforts to pay off any account balance before another procedure begins. For those unable to pay off their balance, the Financial Counselor may set the patient on a payment plan.

2. **Sliding Fee Scale:** Patients who have qualified for the sliding fee discount will be required to pay the entire amount after the discount is applied prior to receiving treatment.

3. **Private Commercial Insurance:** Patients will be responsible to pay the co-payment and any deductible if required by their insurance coverage at time of appointment and prior to any treatment.

It is the responsibility of the patient to contact their insurance company to determine eligibility, benefits and benefit frequency.

Any missed payments after arrangements have been made with our Financial Counselor may result in the account being sent to collections.

Questions? - Please Contact the Financial Counselor at: 509-962-1459

I have read and understand the responsibilities of being a patient at Ellensburg Dental Care:

_____ _____

Patient/Parent or Guardian Signature **Date**

Community Health of Central Washington

Patient's Name: _____ DOB: _____ Medical Record #: _____

PATIENT RESPONSIBILITES- ETIQUETTE

Respect and consideration

You are responsible for being considerate of the rights of other patients and clinic staff. You are responsible for being respectful of the property of others and of the clinic. You understand that any abusive or disrespectful behavior could result in your dismissal from Community Health of Central Washington. This includes

- Using profanity or foul language
- Smoking
- Carrying any weapons
- Acting aggressively, disruptive or threatening
- Taking video or pictures while in any CHCW building without staff consent
- Controlling the noise level of yourself and those with you

Providing information

As a patient you are an integral part of the healthcare team. Therefor you are responsible for:

- Participating in your care and health care decisions
- Providing, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, allergies and other matters relating to your health.
- Communicating whether you clearly understand your plan of care and what is expected of you.

Signature
Patient/Parent/Guardian _____

Date: _____

Community Health of Central Washington

Patient Name:_____ **DOB:**_____

Consent to Disclose Information to Family or Others

Please review the following and **check all boxes that apply:**

☐ I, the above stated patient (or parent/legal guardian of the patient), authorize the staff of CHCW to leave a detailed voicemail at my primary phone number _____.

Please review the following and **check ONE of the options below:**

☐ I, the above stated patient (or parent/legal guardian of the patient), **DO NOT** authorize release of medical information other than what is provided by law.

OR

☐ I, the above stated patient (or parent/legal guardian of the patient), **authorize the following listed person(s)** to be involved in my medical care indefinitely. I authorize the above office to release:

Medical (Med.)	**Financial** (Fin.)
Verbal	Verbal
Written	Written
Paper Prescription	

Required

Please list below who is authorized to receive information from your records:			**Med.**	**Fin.**
Name_____	Relationship_____	Phone_____	☐	☐
Name_____	Relationship_____	Phone_____	☐	☐
Name_____	Relationship_____	Phone_____	☐	☐
Name_____	Relationship_____	Phone_____	☐	☐

I, the above stated patient (or parent/legal guardian of the patient), understand that if this form is not completed correctly, it is invalid and will be destroyed. I also understand that it is my responsibility to update information provided on this form as needed.

_____ _____

Patient Signature (or Parent/Legal Guardian & Relationship) **Date**

Community Health of Central Washington

Health History for Dental Services

The information you provide on this form is important to your dental health and will be completely confidential. If you have any questions, do not hesitate to ask.

Patient Name: _____ Date of Birth: _____

(For patients under 18 only) Mother's Name: _____ Father's Name: _____

Medical Information

YES NO

- ☐ ☐ Have you had a recent illness? _____
- ☐ ☐ Have there been changes in your health or have you been under the care of a physician in the past 2 years?
- ☐ ☐ Are you currently under the care of a physician? If so, what condition(s) are being treated?

  _____

  Physician Name: _____ Phone: _____ City: _____
- ☐ ☐ Have you had any serious illness; operations or been hospitalized in the past 5 years?
  If YES, explain? _____
- ☐ ☐ Are you presently using any medications, drugs, herbs? If YES, what medications are you taking?

  _____
- ☐ ☐ Do you have a history of alcohol or drug abuse? If YES, have you received treatment? Yes or No

  _____
- ☐ ☐ Have you had an orthopedic total joint replacement? If YES, when? _____

Women Only

Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Place an (X) if you have or have had any of the following:

- ☐ Stroke
- ☐ Liver Disease or Hepatitis
- ☐ Diabetes
- ☐ Infectious Mononucleosis
- ☐ Tuberculosis
- ☐ Kidney Treatment
- ☐ Cancer (chemo or radiation therapy)
- ☐ Gastrointestinal Problems
- ☐ Herpes
- ☐ Bleeding Disorder
- ☐ Anemia
- ☐ Rheumatic Fever
- ☐ Asthma
- ☐ Eating Disorder
- ☐ HIV positive
- ☐ Fainting spells or seizures
- ☐ Developmental Disabilities_____
- ☐ Thyroid Troubles
- ☐ Mental Health disorder (specify) _____
- ☐ Respiratory Problems (circle all that apply)

  Chronic Cough Blood tinged sputum

  Unexplained weight loss Other _____
- ☐ Cardiovascular Disease (if YES, circle appropriate selection below)

  Chest Pains Artificial Heart Valves Damaged Heart Valve

  Heart Murmur Heart Attack Mitral Valve Prolapse

  High Blood Pressure Pace Maker

Any conditions not listed above: _____

Allergies – Are you allergic to any of the following:

YES NO YES NO

- ☐ ☐ Local anesthetic ☐ ☐ Latex
- ☐ ☐ Penicillin or other antibiotics ☐ ☐ Sulfa Drugs

Other: _____

Community Health
of Central Washington

Dental Information

1. Are you currently experiencing a dental problem? If so, explain: _____
   _____
2. What type of dental treatment do you feel you need? _____
3. Have you ever had a serious/difficult problem associated with any previous dental treatment? If so, explain:
   _____
4. Date of: last dental exam: _____ Last cleaning: _____ Last Pano: _____
5. Name of Last Dentist: _____ Phone: _____
6. How do you feel about the appearance of your teeth (do you like your smile)? _____

YES	NO	
☐	☐	Have you ever been told you needed antibiotic pre-medication for dental treatment?
☐	☐	Do you often experience a dry mouth?
☐	☐	Are your teeth sensitive to: (circle all that apply) cold hot sweets pressure
☐	☐	Do you grind your teeth at night?
☐	☐	Do you have headaches, earaches or neck pain?
☐	☐	Have you had any periodontal (gum) treatment?
☐	☐	Do your gums bleed when you brush?
☐	☐	Do you have frequent bad breath or an unpleasant taste in your mouth?
☐	☐	Do you use dental floss? If YES, how often? _____ times a week.
☐	☐	Have you had canker/cold sores on your lips, tongue, gums or body?
☐	☐	Have you ever had orthodontic treatment (braces)? If YES, when? _____ Where?_____
☐	☐	Do you use tobacco? Type: _____ How much? _____
☐	☐	*Are you interested in stopping? (Circle one) Very Somewhat Not Interested*
☐	☐	Do you wear any removable dental appliances (complete or partial dentures)?
☐	☐	If YES, date they were made (how old are they)? _____

Patient Signature or (Parent/Guardian, if under 18):_____**Date**_____

Dentist Signature: _____

Updated_____ Dentist Signature _____

Updated_____ Dentist Signature _____

Updated_____ Dentist Signature _____

Community Health of Central Washington

AUTHORIZATION FOR ELLENSBURG DENTAL CARE TO USE OR DISCLOSE MY DENTAL INFORMATION

Patient Name _____ Date of Birth_____Phone#_____
Last First MI

I hereby authorize and request you to release a copy of dental records

TO: (Please provide complete address)	**FROM:** (Please provide complete address)
Dr/Name/Office **Ellensburg Dental Care**	Dr/Name/Office_____
Address **521 E Mountain View Ave**	Address_____
City/State/Zip **Ellensburg, WA 98926**	City/State/Zip_____
Phone # **(509)933-2400**	Phone #_____
Email **dental.reception@chcw.org**	Email/Fax #_____

**Purpose for Release of Records (Please be specific): □ Consult □ Transfer of Care □ Other □ Self

Please send the following information (check applicable lines): **Send to: DENTAL.RECEPTION@CHCW.ORG**

_____ All health care information in my dental record

_____ Specific records related to the following condition: _____

_____ **Specifically exclude**:_____

Note: Under most circumstances, third party records will not be sent.

Read Carefully

I understand that my express consent is required for you to release information relating to sexually transmitted disease, HIV, mental health, and/or drug/alcohol abuse, pursuant to Washington Law RCW 70.24 ET. SEQ.

If I have been tested, treated, or diagnosed in connection with any sexually transmitted disease, or drug/alcohol abuse, and/or illness, you are specifically authorized to release to the person or entity named above all information or medical records relating to such diagnosis, testing, or treatment, unless specifically excluded above. This release is good for 90 days and may be revoked in writing at any time provided the information has not yet been released. Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or Legal authorized Signature _____ Date_____

Relationship (parent, legal guardian, representative, etc.) _____ Date _____

Patient Signature (if over 17 years-of-age) _____ Date _____

IF A PATIENT HAS REACHED HIS/HER THIRTEENTH OR FOURTEENTH BIRTHDAY ONLY THE PATIENT MAY AUTHORIZE DISCLOSURE AS NOTED BELOW:

Consent of Minor (Age 13-17 years-of-age)

I understand that I am entitled to confidential treatment of information relating to treatment of contraception (14-17 years-of-age), pregnancy termination (14-17 years-of-age), sterilization (14-17 years-of-age), sexually transmitted diseases (14-17 years-of-age), mental health conditions (13-17 years-of-age), and/or drug/alcohol abuse (13-17 years-of-age) pursuant to Washington Law RCW 70.02.130 (1). I further understand that my signature below will authorize release of this information.

Patient Signature (If 13-17 years-of-age): _____ Date _____

Community Health
of Central Washington

2024 Discounted Fee Application

Community Health of Central Washington through its clinics provides discounts medical, dental, and mental health services for families at or below 200% of the federal poverty level. If you think you may qualify, fill out the application completely and provide all the necessary documentation described below.

Patient Name: _____ Phone Number: _____ Birth Date: _____

Household Income: Includes the total compensation, welfare, disability, and other payments received from all members within the household.

Total household income: $_____

Family Size: List the names of each family member living within your household.

Family Member Name	*Relationship*	*Birth date*

Total Family Size: _____ ***If more than six list on back***

Verification: Please provide the following documents:

- Previous year's income tax return
- Pay stub from the **most recent 3 months** from each member of the household.
- Any paperwork previously verified from the State, Federal Government, or liable public source:
  - State / Federal application of Aid (Medicaid, food stamps, etc.)
  - Unemployment or disability benefits
  - Social Security income letter for current year
  - Unhoused people, a letter from a shelter, church, physician, or other public source verification.
  - Other (i.e. Student's grant information, etc.)
- Letter from employer verifying income with employer's contact information.
- Letter from Court showing child support or alimony or other payments

☐ I prefer to **not** state my family's size and annual income. ***I understand that I am responsible for the full charge for all services rendered at the clinics of Community Health of Central Washington; and that I must pay for the services on the day I receive them.***

☐ I attest that the information provided above is true and correct. I understand that all discounts are contingent upon verification of required documentation. I further understand that if I do not provide necessary documentation at the time of service, I have 30 business days from the date of this application to provide supporting documents. Otherwise, I will be expected to pay the full amount for services at the time they are rendered. I will be expected to pay the associated fee at the time of each office visit once the application is approved.

_____ _____ _____

Signature of Patient / Guardian Date Signature of **PFC** Proscessing Application

Disclaimer: Community Health of Central Washington has established arrangements with MultiCare Yakima Memorial Hospital, Kittitas Valley Community Hospital, PathologyQuest Diagnostics lab, ; Valley Imaging Partners and Yakima Valley Radiology to provide patient discounted fee program to our patients at or below the federal poverty level.

Community Health
of Central Washington

Discounted Fee Program

February 1, 2024 – January 31, 2025

CHCW's standard fees are discounted based on the current Department of Health and Human Services Federal Poverty Guidelines, as follows.

Table showing Nominal Fee and Board of Directors approved Sliding Fee Scale Discounts Effective 2/1/2024.
For families/households over 12 persons, add $5380 for each additional person.

# of Family/Household members	SFSD A		SFSD B		SFSD C		SFSD D		Self-Pay
Federal Poverty Level (FPL)	0%	100%	101%	133%	134%	166%	167%	200%	Over 200%
1	$ -	$15,060	$15,061	$20,030	$20,031	$25,000	$25,001	$30,120	$30,121
2	$ -	$20,440	$20,441	$27,185	$27,186	$33,930	$33,931	$40,880	$40,881
3	$ -	$25,820	$25,821	$34,341	$34,342	$42,861	$42,862	$51,640	$51,641
4	$ -	$31,200	$31,201	$41,496	$41,497	$51,792	$51,793	$62,400	$62,401
5	$ -	$36,580	$36,581	$48,651	$48,652	$60,723	$60,724	$73,160	$73,161
6	$ -	$41,960	$41,961	$55,807	$55,808	$69,654	$69,655	$83,920	$83,921
7	$ -	$47,340	$47,341	$62,962	$62,963	$78,584	$78,585	$94,680	$94,681
8	$ -	$52,720	$52,721	$70,118	$70,119	$87,515	$87,516	$105,440	$105,441
9	$ -	$58,100	$58,101	$77,273	$77,274	$96,446	$96,447	$116,200	$116,201
10	$ -	$63,480	$63,481	$84,428	$84,429	$105,377	$105,378	$126,960	$126,961
11	$ -	$68,860	$68,861	$91,584	$91,585	$114,308	$114,309	$137,720	$137,721
12	$ -	$74,240	$74,241	$98,739	$98,740	$123,238	$123,239	$148,480	$148,481

Type of Service	SFSD A	SFSD B	SFSD C	SFSD D	Self-Pay Patients
Medical Services Discount	$20 Nominal Fee	$40 Co-payment	$65 Co-payment	$85 Co-payment	No Discount
Dental Services Discount	$45 Nominal Fee	$85 Co-payment	$105 Co-payment	$125 Co-payment	No Discount
Mental Health Discount	$5 Nominal Fee	$5 Co-payment	$5 Co-payment	$5 Co-payment	No Discount
Pharmacy Discount	$5 Fee + Cost of Prescription Drug	$7 Fee + Cost of Prescription Drug	$8 Fee + Cost of Prescription Drug	$9 Fee + Cost of Prescription Drug	No Discount

Patients in SFSD categories B, C, and D; will pay the lesser of the charges or the co-payment.

Pharmacy Services: Prescription Drugs are provided at cost plus a dispensing fee for all medications to patients who are under 200% of the Federal Poverty Level. Self-Pay patients will pay the full retail amount plus a dispensing fee. Payment in full is required at the time of dispensing. ***Services excluded from the SFSD** – Prosthetics, dentures, bleaching, cosmetic surgery, and services provided by other providers who are not part of CHCW. Services discounted separately by the provider (not a CHCW provider); Laboratory services provided by Quest Diagnostics Laboratory, Comprehensive Mental Health Psychiatric consultations, OB Laborist services, referrals to People for People, Valley Imaging Gyn Ultrasound services and Yakima Valley Radiology professional over read fees for X-Rays performed at CHCW.

No patient will be denied services due to inability to pay – Please speak to a patient Financial Counselor if you have questions about your account. Financial Counselors can be reached toll free at 833-574-6100; 8:00 AM to 4:00 PM Monday – Friday; except for Holidays.