RiverStone Health | Dental

Dental Health History

Preferred Name:	First:	Last:	MI:	Pronoun:	Date of Birth:

Tobacco Use

☐ **Non-Tobacco User**

☐ **Former Tobacco User**
How long ago? _____
What age did you start using tobacco? _____

☐ **Current Tobacco User**
☐Cigarettes ☐Vape ☐ Cigar ☐ Other:_____
☐ Smokeless Tobacco Type: _____
Frequency per day? _____
Are you interested in quitting? ☐ **NO** ☐ **Yes**

Medications

Please list the names of any prescription or over-the-counter medications you are taking or have recently taken:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Medical History:

Have you ever had any of the following?

(Check all that apply)

☐ **AIDS / HIV**	☐ **Chemical Dependency**	☐ **Hemophilia**	☐ **Rheumatic Fever**
☐ **Arthritis**	☐ **Chronic Swollen Gums**	☐ **Hepatitis A, B or C**	☐ **Sinus Problems**
☐ **Bleed Heavily**	☐ **Circulatory Problems**	☐ **High Blood Pressure**	☐ **Stroke**
☐ **Take a Blood Thinner**	☐ **Diabetes**	☐ **Low Blood Pressure**	☐ **Heart Attack/M.I.**
☐ **Bruise Easily**	☐ **Seizures**	☐ **Mitral Valve Prolapse**	☐ **Swollen Neck Glands**
☐ **Cancer**	☐ **General Allergies**	☐ **Osteoporosis**	☐ **Thyroid Disease**
If yes, please explain:	☐ **Headaches**	☐ **Ulcer**	☐ **Tuberculosis**
_____	☐ **Heart Murmur**	☐ **Psychiatric Care**	☐ **Other:**
_____	☐ **Respiratory Disease**	☐ **Radiation Treatment**	_____

Do you have a medical Primary Care Provider(PCP) or a medical doctor or advanced practice provider? ☐ **NO** ☐ **Yes**

Doctor's name: _____
Location: _____
If yes, for what are condition(s) are treated? _____
_____

Have you had a serious illness, operation or been hospitalized in the past 5 years? ☐ **NO** ☐ **Yes**

If yes, please explain: _____
_____

Do you have, or have you ever had, any joint replacement?
☐ **NO** ☐ **Yes**

If yes, what joint? _____
How many years ago? _____
Have you been told to take a Pre-med prior to dental visits?
☐ **NO** ☐ **Yes**

Do you have, or have you ever had any of the following cardiac conditions (heart conditions)? ☐ **NO** ☐ **YES**

☐Prosthetic heart valve or valve repair
☐Congenital heart disease or defect
☐History of infective endocarditis
☐Heart Transplant

Are you currently taking a blood thinner (i.e., Warfarin, Heparin, Eliquis, Coumadin, Xarelto)? ☐ **NO** ☐ **Yes**

If yes, what was your last INR? _____ Date: _____

Do you have Diabetes? ☐ **NO** ☐ **Yes** **Type:** _____
If yes, what was your last HbA1c? _____ Date: _____

Are you taking, or have you ever taken, any medications to treat your bones for osteoporosis, bone cancer or Paget's disease (i.e., Reclast, Boniva, Fosamax, Zometa, Actonel, Aclasta, Atelvia, Alendronate)?
☐ **NO** ☐ **Yes**

Are you allergic to, or have you had a reaction to the following?

☐ Local Anesthetic ☐ Codeine or Narcotics ☐ Aspirin
☐ Penicillin or other antibiotics ☐ Other:_____

Any Recreational drug use? ☐ **NO** ☐ **Yes**
If yes, what? _____

Women Only: Are you Pregnant? ☐ **NO** ☐ **Yes** If yes, months pregnant? _____ Nursing: ☐ **NO** ☐ **Yes**
Taking birth control pills or hormone replacement? ☐ **NO** ☐ **Yes**

Patient or Guardian Signature: _____ Date: _____

Guardian Relationship to Patient (please print): _____

RIVERSTONE HEALTH CLINIC

CONSENT FOR TREATMENT /ASSIGNMENT OF BENEFITS

Patient Name: _____ Birthdate: _____

I consent, request and authorize RiverStone Health Clinic to assess, evaluate, and provide care and treatment, including behavioral health ("Treatment") to the patient listed above, including any Treatment rendered via telehealth. Documentation of my Treatment will be a part of my RiverStone Health medical record. I understand that a licensed clinical pharmacist may also participate in my care and as part of my care team to provide, among other benefits, drug therapy management. I may also receive Treatment from students and residents of academic programs who are receiving training at RiverStone Health, including, but not limited to, medical or dental students and medical or dental residents who may participate in my care under applicable supervision requirements. If I do not wish to receive Treatment from a resident or student, I understand it is my responsibility to communicate this wish to my provider.

_____ (Initial Here) I authorize my health care provider and public health agency to collect and enter immunization records into the Montana Department of Public Health and Human Services' confidential Immunization Information System registry. I understand that information in the registry may be released to a public health agency as well as my health care providers to assist in medical care and treatment. In addition, children's immunization information may be released to child care facilities and schools to comply with state immunization requirements. I understand that I can revoke this authorization and have my record removed at any time by contacting my local health department.

I authorize RiverStone Health to access prescription history from outside sources, including but not limited to SureScripts.

I further understand that I am responsible for the costs of my care. I understand that RiverStone Health Clinic offers a Sliding Fee Scale based on family income; if I qualify for the Sliding Fee Scale, I acknowledge that I remain responsible for the remaining balance for my care. I hereby assign any of my health insurance benefits to be paid directly to RiverStone Health Clinic. I authorize the release of medical information related to the payment of those insurance benefits.

I acknowledge that RiverStone Health Clinic is a Patient Centered Medical Home. I will be asked to select a primary care provider and understand that I will be an active participant in my care.

Signature: _____

Date: _____

Updated 2023.03.10

RiverStone Health Clinic

Patient Bill of Rights & Responsibilities

RiverStone Health Copy

Please sign below and return

As a patient, you have the *right* to:	As a patient, you have the *responsibility* to:
Have access to information about your rights and responsibilities. Your family or guardian may exercise your rights if you are judged incompetent or are a minor.	Provide correct and complete information about your medical problems, past illnesses, medications, advance directives and other health issues. Keep the agency informed of changes in name, address, phone number or financial information
Be treated without regard to race, color, religion, sex, handicap, gender preference, national origin, or decision regarding advance directives.	Agree to accept all caregivers without regard to race, color, religion, sex, handicap, gender preference, or national origin.
Be given information about charges for services, including your eligibility for sliding fee scale with income verification.	Be complete and honest in providing income and insurance information. Keep your financial commitments.
Not be physically abused or exploited. Be treated with respect, consideration, dignity and privacy.	Treat staff and other patients with respect and consideration.
Be given information about services available and participate in decisions regarding your care.	Participate in your care. Let your provider know if you do not understand something. Ask questions.
Be given name and job title of each staff member who provides services to you.	Let us know ahead of time if you are unable to keep an appointment.
Participate in decisions regarding your care including decisions about your treatment. You have the right to refuse to participate in experimental research.	Follow your treatment plan. Let your provider know if you are unable to keep your plan.
Be told of the consequences of your actions, if you communicate to your provider that you are refusing treatment.	Accept the consequences if you refuse treatment or if you choose not to follow your treatment plan.
Have protected health information be handled in a private manner and be able to receive a copy of your clinical record if requested.	If you request a copy of your record, there is a fee for this service.
Choose your provider or change your provider at RiverStone Health. Choose or change the provider you are referred to outside of RiverStone Health.	Follow your treatment plan as agreed with your provider. Take medications as directed by your provider. Keep your provider informed of changes in your health.
Voice complaints or suggestions without discrimination or fear of reprisal. Complaints may be made orally or in writing to the Program Manager.	Let the agency know of any problems or if you are unhappy with care or services.
Be informed about making an advance directive (what you want to happen at end of life if you are unable to express your wishes).	Give your provider a copy of your advance directives.
Know what to do in an emergency or after hours.	Take steps to maintain your health when you can. Provide a responsible adult to transport you home from the facility and remain with you for 24 hours, if required by your provider

I have received a copy of the Patient Bill of Rights.

Patient Signature or Guardian

Date

RiverStone Health | Clinic

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have been offered a copy of RiverStone Health's Notice of Privacy Practices that is in effect as of January 1, 2023, in electronic or paper form. I understand I can access a copy of our Notice of Privacy Practices at www.riverstonehealth.org

_____	_____
Patient Signature	Date
_____	_____
Signature of Patient's Representative	Date

New Patient Registration Information

Patient's Legal Name	**Last:**	**First:**	**MI:**	**Today's date:**
Previous Name(s):		**Social Security #:**		
Mailing Address:		**City**	**State**	**Zip**
Street Address *(if different):*		**City**	**State**	**Zip**
Date of Birth (MM/DD/YYYY):	**Email Address:** (To receive secure patient information)			

Phone Numbers: Choose one as a Preferred Phone for Voice Messages

Home: ( ) Preferred ☐	**Work:** ( )
Cell: ( ) Preferred ☐	**Extension:**

Emergency Contact	**Name** *(Last, First):*	**Home:**	**Relationship:**
		Cell:	

Responsible Party	**Relationship:** ☐ **Self** *(If Self, skip to Insurance)* ☐ **Spouse** ☐ **Parent** ☐ **Legal Guardian** ☐ **Other:** _____	**Home::** **Cell:**
	Name *(Last, First):*	**Mailing Address (if different):**
	Date of Birth (MM/DD/YYYY)	**Social Security #:**

Insurance & Hospital Network	**Do you have health insurance?** ☐ **Yes** *Please complete this section* ➔ ☐ **No,** *I would like to talk with a RiverStone Care Manager about possible health insurance options*	**Type of Coverage:** ☐ **Medicaid** ☐ **Medicare** ☐ **Private Insurance** **My insurance carrier is:**	**My preferred hospital network is:** ☐ **Billings Clinic** ☐ **St. Vincent Health Care** ☐ **Beartooth Billings Clinic (Red Lodge)** ☐ **Other:** _____
		I am the: ☐ **Subscriber** ☐ **Dependent**	**Subscriber's Date of Birth** (MM/DD/YYYY)
		Subscribers Full Name, *if not self:*	**Subscriber's Social Security Number**

Facility	**RiverStone location where I plan to receive most or all of my care:**	☐ **Billings – Main Clinic** ☐ **Billings – Dental ONLY** ☐ **Bridger**	☐ **Joliet** ☐ **Worden** ☐ **HCH - MRM**	☐ **Orchard School** ☐ **Medicine Crow Middle School** ☐ **HCH - SVDP** ☐ **HCH - HUB**
Referral	**How did you hear about RiverStone Health?**	☐ **Television** ☐ **Radio** ☐ **Social Media** ☐ **Other** *(Please Specify):*	☐ **Newspaper** ☐ **Billboard** ☐ **Bus Bench**	☐ **Signage on Building** ☐ **Friend/Family** ☐ **Another Provider** *(List Below):*

RiverStone Health | Clinic

Annual Demographic Information

Our goal at RiverStone Health is to help address all the factors that can affect your wellbeing and help connect you to a healthy life. However, you do not need to answer any of these questions, and it will not affect your care here.

Name: _____ **Date of Birth**: _____ **Today's Date**: _____

Pronouns (ex. she, them, he, they, etc.): _____

1. What is your annual household income? _____ ☐ No income ☐ Choose not to answer
How many people (including you) does your income support? _____

2. Employment Status: ☐ Employed full-time ☐ Employed part-time ☐ Not employed ☐ Retired
☐ Migrant ☐ Seasonal ☐ Self Employed ☐ Student part-time ☐ Student-full time ☐ Other

3. Racial Group(s):
Check all that apply

☐ Asian Indian
☐ Chinese
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Filipino
☐ Other Asian

☐ Native Hawaiian
☐ Samoan
☐ Guamanian or Chamorro
☐ Other Pacific Islander

☐ American Indian or Alaska Native
☐ Black or African American
☐ White
☐ Other _____
☐ Declined to Specify

4. Preferred Language *(Choose one)* ☐ English ☐ Español ☐ Français ☐ Portuguese
☐ Other_____ ☐ I need an interpreter *(No cost)*

5. Ethnicity:

☐ Mexican, Mexican American, or Chicano/a

☐ Puerto Rican
☐ Cuban

☐ Another Hispanic, Latino/a or Spanish origin

☐ Not Hispanic, Latino/a or Spanish Origin

☐ Unreported/ Choose Not to Disclose Ethnicity

6. Housing Status:

☐ Own/Rent *(stable housing)*
☐ Perm. Supportive Housing *(Not available in Yellowstone County)*
☐ Living on the street/Vehicle
☐ Other/Hotel

☐ Shelter
☐ Doubling up/ Staying with friends/Couch Surfing

☐ Transitional/Temporary *(Sober living, Family Promise, Independence Hall, for examples)*
☐ Unknown
☐ Decline to answer

7. Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow/Widower ☐ Partnered ☐ Other

8. Veteran Status: Have you ever served in the armed forces? ☐ Yes ☐ No
*(Air Force, Army, Coast Guard, Marines, Navy, Commissioned Officer of the Public Health Service, National Oceanic Atmospheric Administration or **active**-duty National Guard or Reserves)*

9. What was your sex assigned at birth? ☐ Female ☐ Male

10. What is your sexual orientation? ☐ Lesbian or Gay ☐ Bisexual ☐ Choose Not to Disclose
☐ Straight (Not Lesbian or Gay) ☐ Something else ☐ Don't know

11. What is your gender identity? ☐ Male ☐ Transgender to Female ☐ Genderqueer ☐ Choose Not to Disclose
☐ Female ☐ Transgender to Male ☐ Other _____

RiverStone Health Clinic

Sliding Fee Discount Program Enrollment

(Only complete if you are enrolling in the Sliding Fee Program)

Patient Name _____ Date of Birth _____
(Please Print)

Does the patient have any form of health, medical or dental insurance, including Healthy Montana Kids, Medicaid or Medicare? ☐ YES ☐ NO

If yes, list the company and policy number _____

Attach copy of current insurance card.

Number of People in Family (*including self*) _____

Please list people in family or dependents:

	NAME	DATE OF BIRTH
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____

Gross (before taxes) Monthly Income Amount $_____

Type of Documentation of Income: (Attach Copy)

- ☐ Copy of Paycheck Stub Date _____
- ☐ Copy of W-2 or Income Tax Form Date _____
- ☐ Child Support Date _____
- ☐ Other _____ Date _____

The information I have listed above is true and complete. I understand that if it is later found that I did not truly qualify for the sliding fee scale that I may be responsible for repayment of any discounts that I received but was not entitled to. I understand that a person who obtains or attempts to obtain, by fraudulent means, services to which they are not entitled, may be prosecuted under applicable state and federal laws. **I agree to report any changes in the above information.**

Patient Signature: _____ Date: _____

Please fax, mail or bring to RiverStone Health Clinic, 123 South 27th Street, Billings, MT 59101.
Fax: 406.247.3334

Dental Patient Responsibilities

Thank you for choosing RiverStone Health Dental for your dental care needs. We look forward to providing you with excellent dental care. To best serve you and our other patients, we would like to have your agreement with the scheduling guidelines below.

Courtesy Reminders:
Appointment reminder calls/texts are made for patients who have current phone numbers. Patients will be reminded of their upcoming scheduled appointment 1-2 business days prior to the scheduled appointment. Patients who are signed up with the RiverStone Health web portal will also receive an appointment notification via the portal. The patient will be instructed to notify dental if they are unable to keep a scheduled appointment. Dental clinic staff will call patients the day prior to a reserved dental appointment to receive a verbal confirmation if appointment has not already been confirmed.

Cancellations:
We require a 24-hour advance notice if you are unable to make your appointment. Please call us (406) 247-3333, so other patients seeking treatment can have the opportunity to be scheduled. If we do not receive a 24-hour notification for cancellations the appointment will be considered a No-Show Late visit.

Missed appointments:
Patients who miss scheduled appointments will be considered a "No-Show". After the second "No-Show" of a dental appointment within a 6-month period, patients can access Walk-In care for the next 3-months. Once the 3-month time is up the patient can call to reserve dental appointments. Extenuating circumstances of the patient will be taken into consideration.

Patients who have failed a third appointment and have already been asked to wait 3 months prior to rescheduling, will not be scheduled for a reserved dental appointment for 6 months. Extenuating circumstances will continue to be considered by the Dental Clinic Manager. If Patients continue to have repeat failure for missed appointments dental care may be limited to walk-in care only. Patients who may be experiencing scheduling barriers can always contact a Care Manager at (406) 651-6540.

Multiple Family Appointments:
We schedule family members together as a courtesy. If you miss these appointments or fail to cancel at least 24 hours prior, we will be unable to give you future family "group" appointments.

Late Patients:
We make every effort to be on time for all our appointments. Unfortunately, when one patient arrives late, it affects other scheduled patients' treatment. If you arrive later than 10 minutes for your scheduled appointment, the visit will be considered a No-Show Late appointment. The dental team will determine if treatment can still be completed, you can choose to access our Walk-In Dental Care Clinic or reschedule the visit to another appointment time.

Walk-In Dental Clinic:
If you should need urgent or emergent dental care, walk-in availability will be offered to all patients. Based on clinic capacity there could be an unexpected wait time.

Questions and comments:
Should you have any questions or comments, please ask to speak to the Dental Clinic Manager.

Patient Signature (18 yrs. or older)/ Date _____

Parent/Guardian Signature/ Date _____