

PENDER COUNTY DENTAL CLINIC
(910) 259-1503
HOURS M-TH 8:30AM – 4:30PM

PATIENT INFORMATION:

NAME _____ PHONE NUMBER _____
ADDRESS _____ CELL NUMBER _____
_____ Zip _____ WORK NUMBER _____
EMAIL _____ SEX: F M DOB _____
SS# _____ STATUS: SINGLE MARRIED AGE _____
EMPLOYER: _____
IN CASE OF EMERGENCY I AUTHORIZE YOU TO CONTACT _____
PHONE NUMBER _____

AUTHORIZATION TO BILL INSURANCE COMPANY:

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Pender County Health Department Dental Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named dentist may use my health care information and may disclose such information to the above named insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

NO INSURANCE AND I AGREE TO PAY AT TIME OF SERVICE

SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE DATE

PLEASE PRINT NAME OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE DATE

Pender County Health Department Dental Clinic

Form 023: Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I am acknowledging that I have been provided with a copy of Pender County Health Department Dental Clinic's Notice of Privacy Practices dated December 1, 2009 pursuant to the Health Information Portability and Accountability Act of 1996 (HIPAA).

Signature of Patient (or Representative)

Date

Printed name of Patient

Printed name of Representative

Relationship to Patient

Evidence of the authority of the patient's representative must be attached to last page of this acknowledgment

If patient is unable to sign please document the reason and initial: _____

I hereby give Pender County Health Department Dental Clinic permission to leave messages on my telephone answering machine or to whom ever answers the telephone..

I hereby give Pender County Health Department Dental Clinic permission to give information about my health and/or medical condition to the person(s) listed below:

Name

Relationship

Signature of Patient (or Representative)

Date

In order for you, or anyone else, to obtain information from our office about your health and/or medical condition by telephone, the party calling must share a unique and specific patient identifier with our staff.

Patient Identifier: _____

Revised: December 1, 2009

PENDER COUNTY DENTAL

APPOINTMENT POLICY

We, as members of the Pender County Dental Clinic, are committed to provide our clients with the highest quality dental care at extremely affordable fees. Because the cost to operate and provide dental services is significant, we require your support and cooperation to enable us to keep our fees as low as possible.

We understand that sometimes circumstances arise that prevents patients from keeping their appointments. If you need to change or cancel your appointment, please give us a call at least 24 hours in advance. With this prior notice, we can reschedule your appointment and let another patient have the appointment time originally reserved for you. **If you are more than 15 minutes late for your appointment you will be rescheduled and it is considered a missed appointment.

Our policy for missed appointments is as follows:

1 missed appointment: A courtesy letter is sent to inform the patient of our policy.

2 missed appointments: A letter is sent informing the patient that they have missed 2 appointments and if one more appointment is missed then we will no longer be able to schedule appointments on a specific day. The patient will be put on a "Walk-in" appointment list only.

3 missed appointments: A letter is sent informing the patient that they have missed 3 appointments and we can no longer set scheduled appointments for you. The patient is now on the "walk-in" only appointment list for scheduling. Which means, when an appointment is needed the patient will have to call the clinic first thing in the morning and see if there is an available appointment that day. We will be happy to see the patient if the scheduling allows.

**Pender County Dental will not deny anyone emergency care.....if you are having a true emergency then please call the office and we will do our best to fit you in our schedule that week.

Please sign below that you have read and understood the Pender County Dental Appointment Policy:

Signature

Date

PENDER COUNTY HEALTH DEPARTMENT DENTAL CLINIC
803 S. WALKER STREET
BURGAW, NC 28425
910-259-1503

I, _____, consent to be a patient at the above named office and agree to a radiographic and clinical examination. **I also understand and consent to the following:**

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography and photography
2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.
3. No guarantees can be made about treatment outcomes, restoration longevity, or prognosis. I understand that any branch of medicine, including dentistry, is not an exact science and can involve unanticipated results.
4. I will pay in full any cost of treatment or insurance co-payments according to the office's financial policy. I understand that even if insurance provides an estimate or a procedure has been pre-approved, I am responsible for *any* costs that my insurance does not cover.
5. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.
6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

Signature of Patient or Guardian Name

Date

Print Name of Patient or Child

Date

HEALTH HISTORY

English

Patient Name: _____

Patient Identification Number: _____

Birth Date: _____

I. CIRCLE APPROPRIATE ANSWER (Please fill out to the best of your knowledge):

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
If YES, why? _____
4. Yes No Are you being treated by a physician now? For what? _____
Name of Physician: _____ Phone number: _____
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?

II. HAVE YOU EXPERIENCED:

- | | |
|---|-----------------------------------|
| 7. Yes No Chest pain (angina)? | 18. Yes No Dizziness? |
| 8. Yes No Swollen ankles? | 19. Yes No Ringing in ears? |
| 9. Yes No Shortness of breath? | 20. Yes No Headaches? |
| 10. Yes No Recent weight loss, fever, night sweats? | 21. Yes No Fainting spells? |
| 11. Yes No Persistent cough, coughing up blood? | 22. Yes No Blurred vision? |
| 12. Yes No Bleeding problems, bruising easily? | 23. Yes No Seizures? |
| 13. Yes No Sinus problems? | 24. Yes No Excessive thirst? |
| 14. Yes No Difficulty swallowing? | 25. Yes No Frequent urination? |
| 15. Yes No Diarrhea, constipation, blood in stools? | 26. Yes No Dry mouth? |
| 16. Yes No Frequent vomiting, nausea? | 27. Yes No Jaundice? |
| 17. Yes No Difficulty urinating, blood in urine? | 28. Yes No Joint pain, stiffness? |

III. DO YOU HAVE OR HAVE YOU HAD:

- | | |
|--|--|
| 29. Yes No Heart disease? | 41. Yes No AIDS |
| 30. Yes No Heart attack, heart defects? | 42. Yes No Tumors, cancer? |
| 31. Yes No Heart murmurs? | 43. Yes No Arthritis, rheumatism? |
| 32. Yes No Rheumatic fever? | 44. Yes No Eye diseases? |
| 33. Yes No Stroke, hardening of arteries? | 45. Yes No Skin diseases? |
| 34. Yes No High blood pressure? | 46. Yes No Anemia? |
| 35. Yes No Asthma, TB, emphysema, other lung diseases? | 47. Yes No VD (syphilis or gonorrhea)? |
| 36. Yes No Hepatitis, other liver disease? | 48. Yes No Herpes? |
| 37. Yes No Stomach problems, ulcers? | 49. Yes No Kidney, bladder disease? |
| 38. Yes No Diabetes? | 50. Yes No Thyroid, adrenal disease? |
| 39. Yes No Family history of diabetes, heart problems, tumors? | |
| 40. Yes No Allergies? If Yes...please list..... | |

IV. DO YOU HAVE OR HAVE YOU HAD:

- | | |
|------------------------------------|--------------------------------|
| 51. Yes No Psychiatric care? | 56. Yes No Hospitalization? |
| 52. Yes No Radiation treatments? | 57. Yes No Blood transfusions? |
| 53. Yes No Chemotherapy? | 58. Yes No Surgeries? |
| 54. Yes No Prosthetic heart valve? | 59. Yes No Pacemaker? |
| 55. Yes No Artificial joint? | 60. Yes No Contact lenses? |

V. ARE YOU TAKING:

- | | |
|--|---------------------------------|
| 61. Yes No Recreational drugs? | 63. Yes No Tobacco in any form? |
| 62. Yes No Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies? | 64. Yes No Alcohol? |

Please list medications: _____

VI. WOMEN ONLY:

- | | |
|---|--|
| 65. Yes No Are you or could you be pregnant or nursing? | 66. Yes No Taking birth control pills? |
|---|--|

VII. ALL PATIENTS:

67. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If so, please explain: _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's signature: _____

Date: _____

RECALL REVIEW:

1. Patient's signature _____

Date: _____

Doctor's Notes: _____

Doctor's Signature _____

Date: _____