WILKES PUBLIC HEALTH
DENTAL CLINIC

Date _____

****Patient is required to notify office A.S.A.P. if contact information changes!****

PATIENT REGISTRATION

Home Phone_____ **Cell Phone** _____ **Work** _____

Patient _____
LAST NAME FIRST NAME INITIAL PREFERRED NAME

Mailing Address _____ County _____

City _____ State_____ Zip Code_____

Sex: ❑ M ❑ F Birthday _____ Age _____ Social Security # _____

Check Appropriate Box: ❑ Child ❑ Single ❑ Married ❑ Widowed ❑ Divorced/Separated

Race: ❑ White, Non-Hispanic ❑ Black/African American ❑ Hispanic/Latino
❑ Asian/Pacific Islander ❑ American Indian, Eskimo or Aleut ❑ More than one race
❑ Unreported or refused to report

Language: ❑ English ❑ Spanish ❑ Chinese ❑ Russian ❑ Sign Language ❑ Other

Work Status: ❑ Employed ❑ Unemployed ❑ Disabled ❑ Retired ❑ Migrant ❑ Seasonal

Alternate Living Status: ❑ Temporary w/another family ❑ Homeless Shelter ❑ Street ❑ Transitional

Responsible Party _____ Relationship to Patient_____

In case of an emergency, contact number of someone outside the home _____

Relationship _____Phone (_____) _____

Other Family Members That Are Patients _____

_____

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in medical status. I authorize the dental staff to perform the necessary dental services.

_____ _____
Signature of Patient/Legal Guardian Date

Patient Name _____ **DOB** _____ **Date** _____

Parent And Insurance Information

Name of Parent _____
Circle one: Father Stepfather Legal Guardian

Address _____

Home Phone _____ Work Phone _____

Employer _____

SS# _____ Birthdate _____

Name of Parent _____
Circle one: Mother Stepmother Legal Guardian

Address _____

Home Phone _____ Work Phone _____

Employer _____

SS# _____ Birthdate _____

Name of Dental Insurance and Number _____

Name of Second Dental Insurance and Number _____

Name of Insured _____ (If different from above, complete the following) Insured SS# _____ Insured DOB _____

I, the undersigned, have insurance with _____ and assign directly to
Name of Insurance Company (ies)
Wilkes Public Health 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 hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____ _____
Signature of Patient/Parent/Legal Guardian Date

Dental History

Date of last visit to a dentist _____ For what service? _____

Complaints, dental problems, dental pain? Y N

Any injuries to mouth, teeth, head? Y N

Do you brush teeth daily? Y N

Do you floss every day? Y N

Fluoride Supplement/Rinses? Y N

Any unhappy dental experiences? Y N

Do you have removable appliances? Y N

What appliances and how long? _____

Please explain any yes answers? _____

Mouth habits such as nail biting, mouth breathing, thumb sucking, pacifier, sleeping with bottle, etc.?

_____

Patient Name_____ **DOB**_____ **Date**_____

CHILD MEDICAL HISTORY

Physician_____ City/State_____ Phone_____

Date of last physical examination_____ Results_____

Is Minor/Child under care of physician now?..... Y N If so, Who? _____

Are they taking any medications?..... Y N List types:_____

Ever been hospitalized? ..... Y N When and for what?_____

Ever had surgery?..... Y N When and for what?_____

Is there excessive bleeding when cut? ..... Y N Explain?_____

Any allergies? _____

HAS MINOR/CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING?
PLEASE CIRCLE YES (Y) or NO (N)

Y/N AIDS/HIV	Y/N Diabetes	Y/N Liver Disease
Y/N Anemia	Y/N Drug/Alcohol Abuse	Y/N Measles
Y/N Asthma	Y/N Epilepsy	Y/N Mononucleosis
Y/N Bladder Problems	Y/N Fainting	Y/N Mumps
Y/N Blood Transfusions	Y/N Heart Murmur	Y/N Rheumatic Fever
Y/N Cancer	Y/N Heart Problems	Y/N Sinus Problems
Y/N Cerebral Palsy	Y/N Hearing Problems	Y/N Thyroid Disease
Y/N Cold Sores	Y/N Hepatitis	Y/N Tuberculosis
Y/N Chicken Pox	Y/N Kidney Disease	Y/N Autism/Asperger's
Y/N Convulsions	Y/N ADD/ADHD/ODD	Y/N Pregnant/Birth Control
Y/N MRSA	Y/N Developmentally Delayed	Y/N Tobacco Products
Y/N Acid Reflux or GERD	Y/N Artificial Joint/Organ Transplant	

Other _____

Parent/Legal Guardian Signature _____ Date _____

Dentist Signature_____ Date _____

Vitals _____

Staff That Took Vitals and Date _____

WILKES PUBLIC HEALTH
DENTAL CLINIC

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I,_____, have received a copy or have been offered a copy of the
(Patient/Parent/Guardian Name-Printed)

Notice of Privacy Practices of this office or have had a chance to read the posted copy of the **Notice of**

Privacy Practices in the reception area.

My **Protected Health Information** including but not limited to:

1. Information I have completed on any document for the clinic
2. Treatment Information and Consents
3. Appointment Information including broken appointment and patient status
4. Financial Information including insurance coverage, account balance, and financial status

The above four (4) items may be discussed or given to the following authorized individuals.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Print Name of Patient _____

Print Name of Guardian _____

Signature of Patient/Parent/Guardian _____

Date _____

(1-12)

PATIENT POLICIES AND INFORMATION GUIDE

The goal of the Wilkes Public Health Dental Clinic is to provide you with the highest quality dental care possible. You can help us by following our office policies that are listed below.

SAFETY AND PATIENT MANAGEMENT:

- **ONLY THE PATIENT RECEIVING DENTAL TREATMENT IS ALLOWED IN THE TREATMENT ROOM**.

ORAL HYGIENE:

- Each patient will be taught proper tooth brushing, flossing (8 yr old minimum), and other preventive techniques. Patients must brush their teeth for all appointment.

BROKEN APPOINTMENTS AND CANCELLATIONS:

- A **BROKEN APPOINTMENT is** not giving 24 hours notice to reschedule or not arriving for the appointment
- **ONCE YOU BREAK TWO DENTAL APPOINTMENTS YOU WILL NOT RECEIVE ANOTHER SCHEDULED APPOINTMENT**.
- Cancellations must be received at least 24 hours in advance to avoid being charged with a broken appointment**.**
- ***A late arrival of more that 10 minutes may result in you receiving a broken appointment*** and having to reschedule the appointment.

MEDICAID, HEALTH CHOICE, THIRD PARTY COVERAGE, SELF-PAY, OR SLIDING FEES:

- Insurance card and any co-pay (if applicable) are **required at every visit.**
- For self-pay patients, **PROOF OF INCOME** is required at the first visit and annually
- A **MINIMUM FEE IS REQUIRED** at every visit in order to receive another appointment.
- **You will be expected to pay for treatment if not paid by insurance.**
- Outstanding accounts will be given 90 days to make a payment or payment arrangement. If no payment is received, the patient may be sent a dismissal letter until payment is received.

TREATMENT CONSIDERATIONS:

- We may be limited in the services we can provide and you may have needs that cannot be met in our office. We will aid you, to the best of our abilities, to find a dental facility but it is your responsibility to receive or continue treatment. Copies of dental records will be forwarded to another dentist by written request.
- WPHDC cannot assure continuous responsibility of the patient's dental care if your financial status changes, or because of clinical noncompliance (Refusal of X-rays or the doctor's recommended treatment, broken appointments, late for appointments, uncooperative patient, or not following dental staff instruction). After consultation, it will be the patient's responsibility to secure dental care at another dental facility.

CONSENT: I, the undersigned, being the patient (parent/legal guardian if minor), consent to the performing of procedures decided upon to be necessary or advisable in the opinion of the dentist. I request and authorize Wilkes Public Health Dental Clinic to perform treatment.

Print Patient Name:_____ Date:_____

Signature of Patient/Parent/Guardian:_____

(Revised 10-12)

PATIENT CONSENT

FOR PATIENTS UNDER THE AGE OF 18

I, _____, being the parent or legal guardian

of _____, give my permission for the following
Name of Patient
individuals to bring him/her to the Wilkes Public Health Dental Clinic for treatment as presented to me in the treatment plan. I understand that I am responsible for any post-treatment information given to or appointment scheduled by the individuals who brings the child. If additional treatment is needed during the visit, the below name individuals can give consent for this treatment in my absence.

I also understand that if a *treatment specific consent is needed* (Pulling a tooth, Patient Management, Nitrous Oxide Sedation/Laughing Gas, or Root Canal Treatment) that *I must be present to sign these forms* and treatment will be delayed until I am present.

I, _____, give permission as the parent or legal guardian of the child to allow the Wilkes Public Health Dental Clinic to disclose any necessary information regarding treatment or personal health information to the following individuals, even if they are not listed on the Privacy Practices Form.

INDIVIDUALS APPROVED

1. _____

2. _____

3. _____

This agreement may be terminated upon written request.

Patient Name: _____

Signature of Parent or Guardian:_____
Date:_____

WPHDC Staff Signature:_____