Pender County
Health Department

...Building a healthier tomorrow...

Carolyn Moser, BSN, MPA
Health and Human Services Director

Thank you for choosing the Pender County Health Department Dental Clinic for your dental needs. Our goal is to provide the public with quality dental care with lower, more affordable cost. Improving and maintain your oral health is our top priority.

In order to maximize your time with us, we ask you have the following at the time of your appointment:

- Completed medical history
- A complete list of your current medicines
- Completed patient information form
- Current photo ID
- Insurance card and information
- Completed eligibility form with proof of income, if qualifying for a discount
- Any information or radiographs from your previous dentist must be received prior to your appointment

Arriving to your appointment without any of the requested items could cause a delay in your treatment.

We require fees be paid at the time services are rendered.

Thank you for your cooperation

Pender County Dental Clinic Staff

803 S. Walker St., Burgaw, NC 28425 (910) 259-1230 Fax (910) 259-1258

Dental Clinic (910) 259-1503 Environmental Health (910) 259-1233 WIC (910) 259-1290

PENDER COUNTY DENTAL CLINIC
803 S. Walker St. Burgaw NC 28425
(910) 259-1503 Fax (910) 259-1511
HOURS M-TH 8:30AM – 4:00PM

PATIENT INFORMATION:

NAME: _____ "BEST" NUMBER TO CALL:_____
ADDRESS: _____ OTHER NUMBER: _____
_____ Zip:_____ County: _____
DOB: _____ AGE:_____ SEX: F ☐ M ☐ STATUS: SINGLE ☐ MARRIED ☐
Circle Race: Caucasian /Asian /Native Hawaiian / American Indian / Black or African American / Other
Circle Ethnicity: Asian / Hispanic / Non-Hispanic /Middle Easter / Other
SS#: _____ EMPLOYER:_____
Email Address:_____
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:
Insurance carrier: _____
Subscribers Name:_____ ID # or SS# of Subscriber:_____
Subscribers Date of Birth:_____
I 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 clinic 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 _____

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 **OR** if you do not confirm your appointment within 24 hours then 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

Revised May 07, 2015

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. **Please initial below that you understand and consent to the following:**

_____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

_____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.

_____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.

_____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.

_____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.

_____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: _____
Height: _____ Weight: _____ Sex: _____ Date of Birth: _____ Age: _____

General Conditions:
What is your general health? GOOD / FAIR / POOR
Are you being treated a physician? YES / NO. Physician: _____ Phone: _____
Have you been hospitalized for serious illness or injury? YES / NO
If YES, please explain: _____

Skin
y n Eruptions / rash / hives
y n Frequent cold sores / fever blisters

Eyes
y n Blurred vision / Glaucoma

Ears
y n Hearing loss / Ringing in ears / Pain in ears

Respiratory
y n Difficulty breathing / Shortness of breath
y n Difficulty swallowing / Hoarseness
y n Emphysema / Tuberculosis / COPD
y n Asthma / hay fever
y n Other respiratory problem

Nervous System
y n Stroke
y n Epilepsy / seizures
y n Frequent headaches / Head or neck injuries
y n Numbness / Dizziness / Fainting
y n Mental impairment / Dementia

Bones, Muscles
y n Arthritis / Rheumatism / Gout
y n Artificial joints / limbs
y n Osteoporosis / Bone density medicine
y n Fibromyalgia / RSD / Multiple Sclerosis

Heart, Blood Vessels
y n Chest pain / Heart attack / Heart surgery
y n Pacemaker / Artificial heart valve
y n Heart defects /disease / Congestive Heart Failure
y n High / low blood pressure / BP medicine
y n High cholesterol /.Cholesterol medicine
y n Other heart, blood vessel problems

Blood
y n Blood thinner medicine / bleeding problems
y n Anemia or other blood disorders

Digestive
y n Hepatitis / Liver disease
y n Ulcers / Colitis
y n Gastric Reflux (GERD) / Vomiting
y n Other digestive disorders

Endocrine
y n Diabetes / Diabetic medication
y n Thyroid condition / Hormone imbalance

Urinary
y n Kidney / Bladder disease
y n Venereal disease / STD
y n Increased frequency of urination / Blood in urine

Female:
y n Pregnant; # of months ____ due date _____
y n Breast-feeding

Other:
y n Fatigue / Daytime sleepiness / Disruptive snoring
y n Diagnosed with Sleep Apnea?
y n Emotional problems / Easily upset / Depressed
y n Psychiatric treatment
y n Cancer / Radiation / Chemotherapy
y n HIV / AIDS
y n Present/past tobacco use
How much? _____
y n Present/past alcohol use
How much? _____
y n Present/past recreational drug use
_____

Allergies or Drug Reactions: _____

Current / Recent Medications: _____

_____

_____

Other Diseases / Conditions you think we should know about: _____

Dental History:
When was your last dental visit? _____ Problems with prior dental treatment? y /n
How often do you brush? _____ Floss? _____
Consumption of carbonated beverages / Sweets? y / n How much? _____

I have answered every question accurately. I will inform my dentist of any change in my health and/or medication.

Patient Signature _____ Date: _____

For Office Use Only — DOCTOR'S NOTES

BP P