Pender County
Health Department
...Building a healthier tomorrow…

Carolyn Moser, BSN, MPA
Health and Human Services Director

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

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 maintaining 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 form
- ✓ List of your current medications
- ✓ Completed patient information form
- ✓ Current photo ID
- ✓ Insurance information and card
- ✓ 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 to be paid at the time of service.

Thank you for your cooperation,

Pender County Dental Clinic Staff

REGISTRATION FORM

PATIENT INFORMATION:

Date: ________________ Reason For Visit:____

Last Name: _______________________First Name: ________________________Middle Name: _____________________
Date of Birth: ____________ AGE: _____ SEX: F □ M □ STATUS: Single □ Married □ Divorced □ Widowed □
RACE: □ Caucasian □ Asian □ Native Hawaiian □ American Indian □ Black or African American □ Other
ETHNICITY: □ Asian □ Hispanic □ Non-Hispanic □ Middle Eastern □ Other
Preferred Language: ___________________________
Have you or a member of your family been here or to the mobile clinic before? Who? ___________________________
"BEST" Phone Number to Call: ________________________ Other Phone Number: ____________________________
Address: ____
City: ____ Zip:_______________ County: ___________________________
Email Address: ____

Employer:____ SS#: _______________________

IN CASE OF EMERGENCY I AUTHORIZE YOU TO CONTACT:

Last Name: ____ First Name: __________________________________
Relationship: _______________________________________ Phone Number: _______________________________

INSURANCE INFORMATION:

□ **AUTHORIZATION TO BILL INSURANCE COMPANY:**
I certify that I, and/or my dependent(s), have insurance coverage with:
Insurance carrier: ____ ID # or SS# of Subscriber: ____________________
Subscribers Name: ____ 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 OR REPRESENTATIVE **DATE**

PLEASE PRINT NAME OF PATIENT OR 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 1st, 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 acknowledgement.

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 whomever 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 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.
- **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 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 of Patient or Representative Date

____

Name of Patient

PENDER COUNTY HEALTH DEPARTMENT DENTAL CLINIC

803 S. WALKER STREET
BURGAW, NC 28425
910-259-1503

I, _________________________, consent to be a patient at the Pender County Dental Clinic and agree to a radiographic and clinical examination.

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

________I understand that the Pender County Dental Clinic's dentist is adjunct faculty for UNC School of Dentistry, and students or residents may be performing my treatment under the supervision of the health department dentist. The Pender County Dental Clinic's hygienist also works with Cape Fear Community College and Coastal Carolina Community College and students may be performing my treatment under the supervision of the health department hygienist.

________During 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* and all 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 Legal Guardian Date

____ ____________

Print Name of Patient or Child Date

Patient Email and Text Messaging Registration Form

Due to the changing world of healthcare and technology, Pender County Dental Clinic has the ability to provide our patients with certain types of information via email and/or text messaging. If you wish to have the opportunity to receive information of this type, please complete the form below.

Pender County Dental Clinic strongly believes in protecting the privacy of our patients. When you provide this information to us, it is only used to communicate with you. To protect your privacy, no confidential or personal information will be sent from Pender County Dental Clinic via email or text messaging. Pender County Dental Clinic does not share the names, email addresses, and/or cell phone numbers of patients with any other company, or with any other patient. Please update your contact information with us at each visit. Declination can be made at anytime by notifying the office.

Please print all information neat and legibly.

Name____

Email____

Cell Phone____

________ Yes, please sign me up to receive email and text message confirmations.

________ I do not wish to be contacted via email. (Text messaging only)

________ I do not wish to be contacted via text messaging. (Email only)

________ I do not wish to be contacted by either text messaging or email.

I hereby give Pender County Dental Clinic permission to send messages to me via email and or text as a means of communication as indicated by my selection.

____ ________________________

Signature Date

HEALTH HISTORY

Patient Name: ____________________________ Sex: _____ Date of Birth: _____________ Height: ________ Weight: ________

DENTAL HISTORY:

How frequently do you visit a Dentist? ____________________ Last Cleaning: _____________ Last Radiographs: _____________

How often do you brush? ___________Floss? ____________ Difficulty with prior dental treatment? **YES NO**

Consumption of carbonated beverages / Sweets? **YES NO** Oral Habits (clench/grind/nail biting): __________________________

MEDICAL HISTORY:

Medical Doctor's Name: ___________________________________Last seen on: ______________ Phone: __________________

Pharmacy: ____Phone: ___________________

Have you been hospitalized for serious illness or injury? If so please explain:____

____

PLEASE CIRCLE YES OR NO FOR ANY CONDITIONS THAT YOU HAVE OR HAVE HAD:

Skin:

YES NO Eruptions / Rash / Hives
YES NO Frequent cold sores / Fever blisters

Eyes/Ears:

YES NO Blurred vision / Glaucoma
YES NO Hearing loss / Ringing in ears / Pain in ears

Respiratory:

YES NO Difficulty breathing / Shortness of breath
YES NO Sleep Apnea / Snoring
YES NO Difficulty swallowing / Hoarseness
YES NO Emphysema / Tuberculosis / COPD
YES NO Asthma / Pneumonia / Hay Fever
YES NO Chronic Sinusitis

Nervous System:

YES NO Stroke / Cerebrovascular disease
YES NO Epilepsy / Seizures / Last episode: ___________
YES NO Frequent headaches / Migraines / Parkinson's
YES NO Head or neck trauma
YES NO Numbness / Tingling / Dizziness / Fainting
YES NO Dementia / Alzheimer's / Mental impairment

Heart, Blood Vessels:

YES NO Chest pain / Angina
YES NO Heart attack / Congestive Heart Failure
YES NO Pacemaker / ICD / Artificial heart valve
YES NO Heart defects / Heart murmur / Heart surgery
YES NO History of Endocarditis / Valvular heart disease
YES NO High / low blood pressure
YES NO High cholesterol
YES NO Easily bleeding / bruising
YES NO Blood thinner medicine
YES NO History of blood transfusions
YES NO Sickle cell disease/trait
YES NO Anemia / Hemophilia / or other blood disorders

Bones, Muscles:

YES NO Arthritis / Rheumatism / Gout
YES NO Artificial joints / Limbs / Location: __________
YES NO Osteoporosis / Bone density medicine
YES NO Fibromyalgia / RSD / Multiple Sclerosis

Digestive:

YES NO Hepatitis / Liver disease / Type: ____________
YES NO Ulcers / Gastric disease
YES NO Colitis / Crohn's / Celiac / Intestinal disease
YES NO Gastric Reflux / GERD / Vomiting

Endocrine:

YES NO Diabetes / HbA1c or glucose: _____________
YES NO Thyroid condition / Hormone imbalance

Genitourinary:

YES NO Kidney / Bladder disease
YES NO Are you on Dialysis?
YES NO Venereal disease / STD / HIV / AIDS
YES NO Frequent urination / Blood in urine

Female:

YES NO Pregnant: # of months ____due date__________
YES NO Breastfeeding

Other:

YES NO Fatigue / Daytime sleepiness
YES NO Sjorgren Syndrome / Autoimmune disorder
YES NO Phobias / Anxieties / Depression
YES NO Learning Disorders / ADHD / ADD
YES NO Developmental Disorders
YES NO Psychiatric treatment
YES NO Cancer / Radiation / Chemotherapy
YES NO Present/past tobacco use
Frequency: ________________________________
YES NO Present/past alcohol use
Frequency: ________________________________
YES NO Present/past recreational drug use

ALLERGIES OR DRUG REACTIONS:

____

Other Diseases / Conditions you think we should know about**:** ____

*****PLEASE LIST ALL CURRENT MEDICATIONS ON BACK OF THIS FORM.**

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

Patient Signature____Date: ___________________________

Revised May 10, 2021

Please list ALL your prescription drugs, over-the-counter drugs, vitamins, and herbal supplements:

	What I'm taking:	How Much, How often?	For What?
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
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