

# NEW PATIENTS NEED TO PROVIDE ONE OF THE FOLLOWING:

BIRTH CERTIFICATE (for a child)
SOCIAL SECURITY CARD (adult)
VOTER'S CARD
PASSPORT
RESIDENT ALIEN CARD
MARTICULAR CONSULAR CARD

Union County Health Department

For safety reasons, children are not allowed in the room with adults for dental exams and/or treatment. Also children are not allowed to be left unattended in the waiting room.



# PATIENT MEDICAL HISTORY

PATIENT'S NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

	YES	NO		YES	NO
1. ARE YOU IN GOOD HEALTH .....	<input type="checkbox"/>	<input type="checkbox"/>	10. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION .....	<input type="checkbox"/>	<input type="checkbox"/>
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR .....	<input type="checkbox"/>	<input type="checkbox"/>	11. HAVE YOU HAD A RECENT WEIGHT LOSS .....	<input type="checkbox"/>	<input type="checkbox"/>
3. DATE OF YOUR LAST PHYSICAL EXAM: _____			12. HAVE YOU EVER TAKEN FEN-PHEN/REDUX .....	<input type="checkbox"/>	<input type="checkbox"/>
4. PHYSICIAN'S NAME _____ ADDRESS _____ PHONE NO. _____			13. DO YOU USE TOBACCO .....	<input type="checkbox"/>	<input type="checkbox"/>
5. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN .....	<input type="checkbox"/>	<input type="checkbox"/>	14. DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES .....	<input type="checkbox"/>	<input type="checkbox"/>
6. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS PLEASE EXPLAIN. _____	<input type="checkbox"/>	<input type="checkbox"/>	15. ARE YOU WEARING CONTACT LENSES .....	<input type="checkbox"/>	<input type="checkbox"/>
7. ARE YOU TAKING ANY MEDICINE(S) INCLUDING NON-PRESCRIPTION MEDICINE IF YES, WHAT MEDICINE(S) ARE YOU TAKING _____	<input type="checkbox"/>	<input type="checkbox"/>	16. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS) .....	<input type="checkbox"/>	<input type="checkbox"/>
8. HAVE YOU HAD ANY ABNORMAL BLEEDING .....	<input type="checkbox"/>	<input type="checkbox"/>	17. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT .....	<input type="checkbox"/>	<input type="checkbox"/>
9. DO YOU BRUISE EASILY .....	<input type="checkbox"/>	<input type="checkbox"/>	<b>WOMEN ONLY:</b>		
			ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT .....		
			ARE YOU NURSING .....		
			ARE YOU TAKING BIRTH CONTROL PILLS .....		

	YES	NO		YES	NO
ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:			HIVES OR SKIN RASH .....	<input type="checkbox"/>	<input type="checkbox"/>
LOCAL ANESTHETICS LIKE NOVOCAINE .....	<input type="checkbox"/>	<input type="checkbox"/>	FAINTING OR DIZZY SPELLS .....	<input type="checkbox"/>	<input type="checkbox"/>
PENICILLIN OR OTHER ANTIBIOTICS .....	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES .....	<input type="checkbox"/>	<input type="checkbox"/>
SULFA DRUGS .....	<input type="checkbox"/>	<input type="checkbox"/>	AIDS OR HIV INFECTION .....	<input type="checkbox"/>	<input type="checkbox"/>
BARBITURATES, SEDATIVES OR SLEEPING PILLS .....	<input type="checkbox"/>	<input type="checkbox"/>	THYROID PROBLEMS .....	<input type="checkbox"/>	<input type="checkbox"/>
ASPIRIN .....	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIES .....	<input type="checkbox"/>	<input type="checkbox"/>
IODINE .....	<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS OR RHEUMATISM .....	<input type="checkbox"/>	<input type="checkbox"/>
ANY METALS (E.G., NICKEL, MERCURY, ETC.) .....	<input type="checkbox"/>	<input type="checkbox"/>	JOINT REPLACEMENT OR IMPLANT .....	<input type="checkbox"/>	<input type="checkbox"/>
LATEX / RUBBER .....	<input type="checkbox"/>	<input type="checkbox"/>	STOMACH ULCER .....	<input type="checkbox"/>	<input type="checkbox"/>
OTHER (PLEASE LIST) _____			KIDNEY TROUBLE .....	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:			TUBERCULOSIS .....	<input type="checkbox"/>	<input type="checkbox"/>
RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER .....	<input type="checkbox"/>	<input type="checkbox"/>	PERSISTENT COUGH .....	<input type="checkbox"/>	<input type="checkbox"/>
SCARLET FEVER .....	<input type="checkbox"/>	<input type="checkbox"/>	COUGH THAT PRODUCES BLOOD .....	<input type="checkbox"/>	<input type="checkbox"/>
HEART DEFECT OR HEART MURMUR .....	<input type="checkbox"/>	<input type="checkbox"/>	CHEMOTHERAPY (CANCER, LEUKEMIA) .....	<input type="checkbox"/>	<input type="checkbox"/>
HEART TROUBLE, HEART ATTACK, OR ANGINA .....	<input type="checkbox"/>	<input type="checkbox"/>	SEXUALLY TRANSMITTED DISEASE .....	<input type="checkbox"/>	<input type="checkbox"/>
CHEST PAIN .....	<input type="checkbox"/>	<input type="checkbox"/>	EPILEPSY OR SEIZURES .....	<input type="checkbox"/>	<input type="checkbox"/>
SHORTNESS OF BREATH .....	<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA .....	<input type="checkbox"/>	<input type="checkbox"/>
PACEMAKER .....	<input type="checkbox"/>	<input type="checkbox"/>	GLAUCOMA .....	<input type="checkbox"/>	<input type="checkbox"/>
HEART SURGERY .....	<input type="checkbox"/>	<input type="checkbox"/>	NERVOUSNESS .....	<input type="checkbox"/>	<input type="checkbox"/>
HIGH/LOW BLOOD PRESSURE .....	<input type="checkbox"/>	<input type="checkbox"/>	TONSILLITIS .....	<input type="checkbox"/>	<input type="checkbox"/>
CONGENITAL HEART PROBLEM .....	<input type="checkbox"/>	<input type="checkbox"/>	TUMORS .....	<input type="checkbox"/>	<input type="checkbox"/>
SWELLING OF FEET, ANKLES, HANDS .....	<input type="checkbox"/>	<input type="checkbox"/>	MENTAL HEALTH CARE .....	<input type="checkbox"/>	<input type="checkbox"/>
HEPATITIS, JAUNDICE OR LIVER DISEASE .....	<input type="checkbox"/>	<input type="checkbox"/>	BACK PROBLEMS .....	<input type="checkbox"/>	<input type="checkbox"/>
STROKE .....	<input type="checkbox"/>	<input type="checkbox"/>	CHEMICAL DEPENDENCY .....	<input type="checkbox"/>	<input type="checkbox"/>
SINUS TROUBLE .....	<input type="checkbox"/>	<input type="checkbox"/>	MITRAL VALVE PROLAPSE .....	<input type="checkbox"/>	<input type="checkbox"/>
LUNG OR BREATHING PROBLEMS .....	<input type="checkbox"/>	<input type="checkbox"/>	CORTISONE TREATMENT .....	<input type="checkbox"/>	<input type="checkbox"/>
ASTHMA OR HAY FEVER .....	<input type="checkbox"/>	<input type="checkbox"/>	COLD SORES/FEVER BLISTERS .....	<input type="checkbox"/>	<input type="checkbox"/>
			HYPOGLYCEMIA .....	<input type="checkbox"/>	<input type="checkbox"/>
			EATING DISORDERS .....	<input type="checkbox"/>	<input type="checkbox"/>

ITEM 07-0515775/27011

PATIENT NUMBER \_\_\_\_\_

HEALTH HISTORY

# PATIENT DENTAL HISTORY

PATIENT'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

REASON FOR THIS VISIT \_\_\_\_\_

WHEN WAS YOUR LAST DENTAL VISIT \_\_\_\_\_ WHAT WAS DONE THEN \_\_\_\_\_

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN \_\_\_\_\_

PREVIOUS DENTIST (NAME AND LOCATION) \_\_\_\_\_

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN WHEN WHERE \_\_\_\_\_

HOW OFTEN DO YOU BRUSH YOUR TEETH \_\_\_\_\_ HOW OFTEN DO YOU FLOSS YOUR TEETH \_\_\_\_\_

IS YOUR DRINKING WATER FLUORIDATED \_\_\_\_\_

	YES	NO		YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING .....	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY .	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS.....	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH .....	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS.....	<input type="checkbox"/>	<input type="checkbox"/>	DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH .....	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU FEEL PAIN TO ANY OF YOUR TEETH.....	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS).....	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH .....	<input type="checkbox"/>	<input type="checkbox"/>	EVER WORN A BITE PLATE OR OTHER APPLIANCE. . .	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES.	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST .....	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?			HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS.....	<input type="checkbox"/>	<input type="checkbox"/>
CLICKING .....	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU WEAR DENTURES OR PARTIALS .....	<input type="checkbox"/>	<input type="checkbox"/>
PAIN (JOINT, EAR, SIDE OF FACE) .....	<input type="checkbox"/>	<input type="checkbox"/>	IF YES, DATE OF PLACEMENT _____		
DIFFICULTY IN OPENING OR CLOSING .....	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS .....	<input type="checkbox"/>	<input type="checkbox"/>
DIFFICULTY IN CHEWING.....	<input type="checkbox"/>	<input type="checkbox"/>			
DO YOU HAVE FREQUENT HEADACHES .....	<input type="checkbox"/>	<input type="checkbox"/>			
DO YOU CLENCH OR GRIND YOUR TEETH.....	<input type="checkbox"/>	<input type="checkbox"/>			

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? \_\_\_\_\_

\_\_\_\_\_

**AUTHORIZATION AND RELEASE**

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

X \_\_\_\_\_ DATE \_\_\_\_\_  
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

DOCTOR'S COMMENTS \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PATIENT NUMBER \_\_\_\_\_

# Union County Health Department Notice and Consent to Financial Policies

Medicaid _____
HealthChoice _____
Other Insurance: <i>Complete Verification of Pt Insurance Form</i>

Thank you for choosing Union County Health Department (UCHD) for your services. Please carefully review UCHD's financial policies as set forth in this Notice and Consent form and sign below.

**Fee Adjustments.** To be eligible for fee adjustments based on income, I must present income documentation at the time of my appointment or by 5 pm the next business day. Otherwise, I will be charged at 100%. I give permission for UCHD to check household income and insurance coverage through employers and other sources as necessary to determine my eligibility for services. I will notify UCHD of any changes in household income and these changes will be verified through the employer/other agencies and charges will be adjusted as necessary. I understand that I may receive services or be referred for services provided by other physicians, laboratories, hospitals or other agencies, and that fees charged for such services are my personal responsibility. I also understand that fees charged by UCHD may be adjusted due to income and that this adjustment does not apply to fees charged by other persons or entities outside of UCHD.

**Insurance.** I will inform UCHD if I have insurance now or if I should get insurance coverage in the future. Insurance co-payments are due at time of service. UCHD will file insurance claims for me, however, I will pay on the remaining balance if Medicaid/other insurance does not pay within 60 days. I request that Medicaid, Medicare, or other insurance payment for services that I receive through UCHD is to be paid directly to UCHD. I agree to pay to UCHD any monies that I receive from any source that is sent directly to me as payment for services that I received at UCHD. I will make this payment within 45 days of the day that I receive these monies.

**Assessment and Payment of Fees.** At each visit I will be charged an estimated fee for the services I received. However, if UCHD fails to charge me the full amount on the date of service, these fees will be added to my account. I am personally responsible for any part of my bill not covered by Medicaid, Medicare, or other insurance, and I am expected to pay for any uncovered services at the time of my visit. Payments may be made with cash, check, credit or debit card. My account will be charged a \$20 returned check fee for any non-sufficient funds checks I write to the UCHD. I understand that if outstanding balances remain unpaid, UCHD has the right to: (i) Refuse to provide further services to you, other than those mandated by State law; (ii) Institute a civil action against you; (iii) Submit your outstanding debt to the North Carolina Debt Setoff Collection Clearing House, pursuant to which qualifying debts may be automatically deducted from any State tax refund you may be owed; and/or (iv) Refer your account to a collection agency. If my account balance should reach \$150 or more, I will be placed on a Payment Plan. Failure to make a "good faith effort" to pay on the Payment Plan may result in denial of certain services or service limitation.

**Release of Medical Information.** I give permission for UCHD to release any medical information (including information regarding chemical dependency problems and/or treatment, HIV/AIDS information, drug screen results and assessment), which is requested by Medicaid, Medicare, other insurance companies, or other agencies assisting in my care, in accordance with State and Federal law.

**Duration of Consent.** I understand that this consent will remain in effect while I am receiving care at UCHD and/or until all unpaid accounts with UCHD are settled. I also understand that I may cancel this consent in writing delivered to UCHD anytime during our normal business hours.

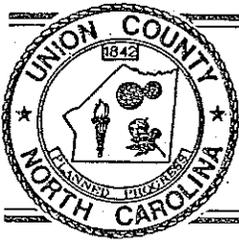
**Consent to Comply.** I have read these Financial Policies. I was given the opportunity to ask questions and I received answers to my questions. I agree to comply with these Financial Policies.

\_\_\_\_\_  
Date of Signature

\_\_\_\_\_  
Patient/Responsible Party/Guardian Signature

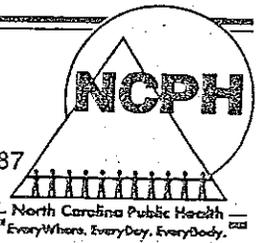
\_\_\_\_\_  
Date of Signature

\_\_\_\_\_  
UCHD Staff Signature



# Union County Health Department

1224 W. Roosevelt Blvd. • Monroe, NC 28110 • Phone (704) 296-4800 • Fax (704) 296-4887



## SCHEDULING POLICY

Place label here

In order to better serve our patients, the following scheduling policy will be strictly enforced:

1. You **MUST** give **24 HOURS NOTICE** for all **CANCELLATIONS**.

If no notice is given and you do not show for your appointment it will be considered a **BROKEN APPOINTMENT**, After (Two) broken appointments, a letter of dismissal will be mailed to you. After one year from the dismissal letter, you will be able to be reinstated as our patient.

Emergency treatment will be provided for 30 days following the dismissal letter. During this time, it is your responsibility to find another dental provider. After 30 days, no further treatment will be provided by the Union County Dental Clinic. Thank you for your cooperation.

\_\_\_\_\_  
Parent/Legal Guardian/Patient

\_\_\_\_\_  
Date

UNION COUNTY HEALTH DEPARTMENT  
DENTAL CLINIC  
704-296-4829

*Place Label Here*

INFORMED CONSENT

Permission for Dental Examination and Treatment

I am the parent/legal guardian of \_\_\_\_\_, who is a minor child, and I do hereby authorize and consent to any dental examination, x-rays, anesthetic, or dental treatment including tooth extraction rendered under the general, direct or indirect supervision of Dr. Candace Crowe and staff members or agents as they may deem necessary.

If I am unable to accompany my child at any future dental appointment, I authorize \_\_\_\_\_ to accompany my child to the Dental Clinic and to act in my stead.

This authorization will remain in effect until cancelled in writing by me.

OR

I am \_\_\_\_\_, and do hereby authorize and consent to any dental examination, x-rays, anesthetic, or dental treatment including tooth extraction rendered under the general, direct or indirect supervision of Dr. Candace Crowe and staff members or agents as they may deem necessary.

This authorization will remain in effect until cancelled in writing by me.

\_\_\_\_\_  
Parent/Legal Guardian / Patient

\_\_\_\_\_  
Date

**UNION COUNTY**  
**HEALTH DEPARTMENT**  
**DENTAL CLINIC**

**POLICIES**

Place label Here

1. ALL appointments require a 24-hour notice for cancellations in order to be reappointed.
2. **THE PARENT OR GUARDIAN OF THE CHILD BEING TREATED MAY NOT LEAVE THE BUILDING FOR ANY REASON.**
3. Any patient who reports more than 10 minutes late for an appointment may have to be reappointed for the next available day our schedule allows.

*I have read the above written policy and comply:*

---

Signature of Parent /Legal Guardian/Patient

Date

\_\_\_\_\_  
Last Name                      First Name      MI

\_\_\_\_\_  
Patient SS#:

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date of Birth:

NC Department of Health and Human Services  
Public Health Nursing

**PERMISSION TO USE AND DISCLOSE  
PATIENT HEALTH INFORMATION**

I hereby acknowledge that I have received a copy of the "Notice of Privacy Practices" for \_\_\_\_\_ County/District Health Department and understand that I may contact the person named therein if I have questions about the content of the notice.

\_\_\_\_\_  
Patient/Parent/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

I give my voluntary consent for \_\_\_\_\_ County/District Health Department to use and disclose health/medical information regarding

\_\_\_\_\_  
Patient name

for purposes of treatment, payment and health care operations.\* I understand that the health/medical information used and disclosed may include information about communicable diseases (such as HIV). I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it. I understand that this consent is valid until I revoke it and that if I want to revoke this consent I must do so in writing.

\* See our "Notice of Privacy Practices" for explanations of the terms "treatment," "payment," and "health care operations."

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of parent, legal guardian, or other legally responsible person (when required)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date