



**Macon County
Public Health**

Welcome to Macon County Dental Services

Macon County Public Health accepts Medicaid, NC Health Choice, patient pay and some private dental insurance plans. Sliding Fee payment options are available based on household size and income. **Proof of income is required** to qualify for the Sliding Fee. Payment is expected at time of service. We accept cash, Mastercard, Visa or personal checks. Your insurance will be billed but a copy of your insurance card is required.

Services offered include; cleanings, comprehensive & periodic exams, digital x-rays, extractions, fillings, partials, dentures, preventive fluoride, sealants and limited emergency services. Patients that arrive more than 10 minutes past their appointment time will be required to reschedule.

If you would like to make an appointment or have further questions, please call **Adult Dental at 828-349-2588 or the Moler Roller for Children's Dental services at 828-349-2513** or visit: www.maconnc.org or [www.Facebook.com/MaconPublicHealth](https://www.facebook.com/MaconPublicHealth). Please use blue or black ink.

Full Legal Name:	First	Last	MI
Social Security:			Sex: M or F
Date of Birth:		Country Of Birth:	County of Residence:
Race (check):	<input type="checkbox"/> White <input type="checkbox"/> White-Hispanic Origin <input type="checkbox"/> American Indian/Native Alaskan <input type="checkbox"/> Black <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other: _____		
Other (check/list):	<input type="checkbox"/> Seasonal Farm Worker <input type="checkbox"/> Migrant Farm Worker <input type="checkbox"/> Homeless English Speaking: Yes (or) No If Interpreter Required, please list Language: _____		
Email Address:			
Address:	street address		city
	mailing address if different than above		State/ Zip
Phone Contact:	home	cell and/or pager	work phone
Emergency Phone:	name of contact/relationship to Patient		emergency phone number
Have you ever received services at Macon County Public Health under a different name:			
Previous Dentist:	Address:		
Last Visit:	Phone:		
List Other Persons Living In Home (use back of form if additional space req.)	DOB	Sex	Relationship to Patient
Insurance Company: _____			
Subscriber's Name _____		Subscribers Date of Birth _____	
A copy of the insurance card is required.			