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 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, 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
the Molar Roller for Children's Dental services at 828-349-2513
or visit: www.maconnc.org or 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):	☐ White ☐ White-Hispanic Origin ☐ American Indian/Native Alaskan ☐ Black ☐ Asian/Pacific Islander ☐ Other: _____		
Other (check/list):	☐ Seasonal Farm Worker ☐ Migrant Farm Worker ☐ 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.

Last Name First Name MI

Date of Birth

Macon County Public Health

Acknowledgement Receipt of "Notice of Privacy Practices"

By signing below, I am acknowledging that:

I am either the patient or the patient's personal representative and I have received a copy of the "Notice of Privacy Practices" of Macon County Public Health. I understand that I may contact the person named in the "Notice" if I have questions about the content of the "Notice".

I understand that if services are rendered to me and I am not eligible for insurance, at the time of service that I will be responsible for any expenses incurred during that visit.

All telephone numbers provided may be subject to receiving telephone calls from an automated dialer using a pre-recorded, artificial voice message or live operator call. I give my express consent to receive such phone calls, including any calls made to the cellular telephone number that I have provided

☐ **I authorize the release of any medical/dental or other information necessary to process this claim for payment. I request payment of benefits to Macon County Public Health and assigned entities or suppliers of services.**

OR

☐ **I have medical/dental insurance but choose <u>not</u> to have them billed for today's services.**

Signature of patient or parent/legal guardian/legally responsible person **Date**

Relationship to patient

To Be Completed by Staff
Complete all applicable parts – Please refer to Instructions

Part 1. Complete if signature requested but not obtained:
Staff member sought but was unable to obtain an acknowledgment from the patient or the patient's personal representative for the following reason:

☐ Patient/personal representative refused to sign form
☐ Other _____

Part 2. Complete if patient/personal representative unavailable to sign form on first date of service delivery:
☐ Form mailed/sent to patient/personal representative on _____ (Date)

Signature of staff member Date

Last Name First Name MI

Date of Birth

Macon County Public Health

Consent for Dental Examination and Treatment

By signing this Consent:

1. I authorize Macon County Dental Services to provide all necessary dental care recommended. If the patient is a minor, as parent/guardian, I authorize consent without me being present for the procedures.
2. I understand the dental staff will perform an oral examination on myself/child and provide needed dental care based on the dentist's findings. Dental treatments may include but are not limited to; cleanings, fluoride, sealants, digital x-rays, fillings, extractions, limited replacement options such as partials or dentures, stainless steel crowns, space maintainer and pulpotomies.
3. In the event that my child needs a primary tooth (baby tooth) extracted, I give consent for this extraction
4. I understand the emergency dental treatment may be limited and is done to relieve pain, swelling, infection and injury.
    a. If a referral to a specialist is required for continuity of dental care, a Release of Records Form must be completed.
    b. I authorize Macon County Public Health to share copies of my Treatment Plans and Treatment Schedules with agencies such as Macon Program for Progress (Head Start Program), Nursing Home Facilities, Physicians and DSS upon receiving written request from said facility for the purpose of coordinating care or your participation in their programs.
5. Sometimes problems can occur. I understand that there are risks in dental treatment; which may include pain/soreness, swelling, infection, bleeding, injury to nearby teeth or gums, problems with joints in the mouth or jawbone, numbness, and allergic reactions.
6. I have been given the opportunity to have all my questions answered and agree to have myself or my child participate in the dental program.
7. Macon County Public Health accepts Medicaid, NC Health Choice, patient pay and some private dental insurance plans. Patients who have no dental insurance may qualify for sliding fee scale based on your family size and income. You are required to notify staff immediately when your insurance coverage changes. I understand that if services are rendered to me and I am not eligible for insurance, at the time of service that I will be responsible for any expenses incurred during that visit.
8. Failure to comply with the above stated responsibilities Macon County Public Health reserves the right to reschedule your visit, refer the patient to another practice or dismiss you from our clinic.

Signature of Patient, Parent, or Guardian Date

Relationship to Patient

Macon County
Public Health

Medical History Form

Patient Name:

Date of Birth:

Sex:

Emergency Contact _____
Emergency Contact Phone _____
Emergency Contact Relationship _____

Do you have any of the following diseases or problems

Active Tuberculosis	Yes	No
Persistent cough greater than a 3 week duration	Yes	No
Cough that produces blood	Yes	No
Been exposed to anyone with tuberculosis	Yes	No

Medical History

Are you now under the care of a physician?	Yes	No
Physician Name _____		
Phone (including area code) _____		
Address/City/State/Zip _____		
Are you in good health?	Yes	No
Has there been any change in your general health within the past year?	Yes	No
If yes, what condition is being treated? _____		
Date of last physical exam _____		
Have you had a serious illness, operation or been hospitalized in the past 5 years?	Yes	No
If yes, what was the illness or problem? _____		
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	Yes	No
If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements		
_____		
Do you wear contact lenses?	Yes	No
Joint Replacement. Have you had any orthopedic total joint (hip, knee, elbow, finger) replacement?	Yes	No
Date _____		
If yes, have you had any complications? _____		
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	Yes	No
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous biphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	Yes	No
Date Treatment began _____		
Do you use controlled substances (drugs)?	Yes	No
Do you use tobacco (smoking, snuff, chew, bidis)?	Yes	No
If so, are you interested in stopping? VERY / SOMEWHAT / NOT INTERESTED _____		
Do you drink alcoholic beverages?	Yes	No
If yes, how much alcohol did you drink in the last 24 hours? _____		
If yes, how much do you typically drink in a week? _____		

WOMEN ONLY. Are you:

Pregnant
Number of weeks
Taking birth control pills or hormonal replacement?
Nursing?

CONTINUE ON NEXT PAGE →

Allergies, Are you allergic to or have you had any reaction to

Local anesthetics	Yes	No	Latex (rubber)	Yes	No
Aspirin	Yes	No	Iodine	Yes	No
Penicillin or other antibiotics	Yes	No	Hay fever/seasonal	Yes	No
Barbiturates, sedatives, or sleeping pills	Yes	No	Animals	Yes	No
Sulfa drugs	Yes	No	Food	Yes	No
Codeine or other narcotics	Yes	No	Other	Yes	No
Metals	Yes	No	If Other, please specify: _____		

Congenital Heart Disease (CHD) - Please indicate if you have had or not had any of the following:

Artificial (prosthetic) heart valve	Yes	No	Unrepaired, cyanotic CHD	Yes	No
Previous infective endocarditis	Yes	No	Repaired (completely) in the last 6 months	Yes	No
Damaged valves in transplanted heart	Yes	No	Repaired CHD with residual defects	Yes	No
Congenital heart disease (CHD)	Yes	No			

Other Diseases and Conditions - Please indicate if you have had or not had any of the following:

Cardiovascular disease	Yes	No	Blood transfusion	Yes	No
Angina	Yes	No	If yes, date _____		
Arteriosclerosis	Yes	No	Hemophilia	Yes	No
Congestive heart failure	Yes	No	AIDS or HIV	Yes	No
Damaged heart valves	Yes	No	Arthritis	Yes	No
Heart attack	Yes	No	Autoimmune disease	Yes	No
Heart murmur	Yes	No	Rheumatoid arthritis	Yes	No
Low blood pressure	Yes	No	Systemic lupus erythematosus	Yes	No
High blood pressure	Yes	No	Asthma	Yes	No
Other congenital heart defects	Yes	No	Bronchitis	Yes	No
Mitral valve prolapse	Yes	No	Emphysema	Yes	No
Pacemaker	Yes	No	Sinus trouble	Yes	No
Rheumatic fever	Yes	No	Tuberculosis	Yes	No
Rheumatic heart disease	Yes	No	Cancer/Chemotherapy/Radiation Treatment	Yes	No
Abnormal bleeding	Yes	No	Chest pain upon exertion	Yes	No
Anemia	Yes	No	Chronic pain	Yes	No
Diabetes Type I or II	Yes	No	Sleep disorder	Yes	No
Eating disorder	Yes	No	Mental health disorders	Yes	No
Malnutrition	Yes	No	Specify _____		
Gastrointestinal disease	Yes	No	Recurrent infections	Yes	No
G.E. Reflux/persistent heartburn	Yes	No	Type of infection	Yes	No
Thyroid problems	Yes	No	Kidney problems	Yes	No
Stroke	Yes	No	Night sweats	Yes	No
Glaucoma	Yes	No	Osteoporosis	Yes	No
Hepatitis, jaundice or liver disease	Yes	No	Persistent swollen glands in neck	Yes	No
Epilepsy	Yes	No	Severe headaches/migraines	Yes	No
Fainting spells or seizures	Yes	No	Severe or rapid weight loss	Yes	No
Neurological disorders	Yes	No	Sexually transmitted disease	Yes	No
If yes, please specify _____			Excessive urination	Yes	No

Premedication

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes No

Name of physician or dentist making recommendation (include phone number) _____

Do you have any disease, condition, or problem not listed above that you think I should know about? Yes No

Please explain _____

_____

Signature of Patient/Legal Guardian Date