Department of Human Services
Division of Public Health- Dental Clinic
2330 Concord Ave
Monroe, NC 28110

T. 704-296-4829
F. 704.296.4807
www.unioncountync.gov

DEMOGRAPHIC INFORMATION

DATE:_____

PATIENT'S NAME:
(Name should be listed EXACTLY as it appears on Patient's Birth Certificate, I.D and Medicaid/Health Choice.)

_____
Last First M.I.

BIRTHDATE _____

SOCIAL SECURITY# _____

GENDER _____ **RACE**_____ **LANGUAGE**_____

PARENT/GUARDIAN'S NAME: _____
(1F APPLICABLE) Last First MI Social Security#

ADDRESS/ P.O BOX: (Name of the Street and Number) _____

_____
City State Zip Code

HOME/CELL _____ **WORKPHONE:**_____

EMERGENCY CONTACT PERSON NAME & PHONE NUMBER

_____

DENTAL INSURANCE NAME AND NUMBER

_____

Union County Government
EST. 1842

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MEDICAL AND DENTAL HISTORY

Patient Name: _____Nickname:_____DOB_____Name of Physician/Specialty_____

Date most recent physical examination_____ How would you estimate your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

1. When was your last Dental Visit_____
2. Do you have any soars or lumps in or near your mouth? Yes ☐ No ☐
3. Have you ever had periodontal treatment (Gums)? Yes ☐ No☐
4. Do you feel pain to any of your teeth? Yes ☐ No ☐
5. Is your drinking water fluoridated? Yes ☐ No ☐
6. Do your gums bleed while brushing Yes ☐ No ☐
7. Have you had any head, neck or jaw injuries? Yes ☐ No ☐
8. Have you had any difficult extractions in the past? Yes ☐ No ☐
9. Have you ever had any prolonged bleeding following extractions? Yes ☐ No ☐
10. Do you have a high level of anxiety for dental visits/treatment? Yes ☐ No ☐

DO YOU HAVE OR HAVE YOU EVER HAD:

1. Hospitalization for illness or injury : ☐ Yes ☐ No If yes, Date of hospitalization _____
2. An allergic reaction to: (Mark all that apply)

☐ Aspirin ☐ Ibuprofen ☐ Acetaminophen ☐ Codeine ☐ Penicillin ☐ Erythromycin ☐ Tetracycline ☐ Sulfa ☐ Local Anesthetic ☐ Fluoride

☐ Metals: nickel, gold, silver, _____ ☐ Latex ☐ Other _____

3. Heart problems, or cardiac stent within the last six month___ Yes ☐ No ☐
4. History of infective endocarditis_____ Yes ☐ No ☐
5. Artificial heart valve, repaired heart defect (PFO) _____ Yes ☐ No ☐
6. Pacemaker or implantable defibrillator_____Yes ☐ No ☐
7. Orthopedic Implant (joint replacement) _____ Yes ☐ No ☐
8. High or low blood pressure _____ Yes ☐ No ☐
9. A stroke (taking blood thinners) _____ Yes ☐ No ☐
10. Rheumatic or scarlet fever_____ Yes ☐ No ☐
11. Anemia or other blood disorder_____ Yes ☐ No ☐
12. Prolonged bleeding due to a slight cut (INR>3.5)_____ Yes ☐ No ☐
13. Emphysema, shortness of breath, Asthma _____ Yes ☐ No ☐
14. Tuberculosis, measles, chicken pox _____ Yes ☐ No ☐
15. Kidney Disease _____ Yes ☐ No ☐
16. Liver Disease _____ Yes ☐ No ☐
17. Thyroid, parathyroid disease, or calcium deficiency _____ Yes ☐ No ☐
18. High cholesterol or taking statin drugs _____ Yes ☐ No ☐
19. Diabetes (HbA1c-____) _____ Yes ☐ No ☐
20. Stomach or Digestive Disorders (i.e. celiac, gastric reflux, ulcer)____ Yes ☐ No ☐
21. Osteoporosis/osteopenia (i.e. taking bisphosphonates)_____ Yes ☐ No ☐
22. Arthritis_____ Yes ☐ No ☐
23. Glaucoma_____ Yes ☐ No ☐
24. Autoimmune disease (i.e. lupus, scleroderma)_____ Yes ☐ No ☐
25. Neurologic disorders (ADD/ADHD, prion disease)_____ Yes☐ No ☐
26. Epilepsy, convulsions (seizures)_____Yes ☐ No ☐
27. Hives, skin rash, hay fever_____ Yes ☐ No ☐
28 STI/STD/HPV_____ Yes ☐ No ☐
29. HIV / AIDS_____ Yes ☐ No ☐
30. Tumor, abnormal growth_____ Yes ☐ No ☐
31. Radiation Therapy, Chemotherapy_____ Yes ☐ No ☐
32 Emotional difficulties_____ Yes ☐ No ☐
33. Psychiatric Treatment_____ Yes ☐ No ☐
34. Alcohol / recreational drug use_____ Yes ☐ No ☐

CURRENTLY:

35. Any health changes in the last 24 hours (i.e. fever, chills, new cough, diarrhea) _____ Yes ☐ No ☐
36. A smoker, smoked previously or use smokeless tobacco_____ Yes ☐ No ☐
37. FEMALE-taking birth control pills_____ Yes ☐ No ☐
38. FEMALE-pregnant_____ Yes ☐ No ☐

Describe any medical treatment, impending surgery, genetic/developmental delay, or other treatment that you feel we should know.

_____

List all medications, supplements, and or vitamins taken within the last two years. (*Use another sheet of paper for additional listing, if necessary).*

DRUG	PURPOSE	DRUG	PURPOSE

_____ _____
Patient's Signature Date Doctor's Signature Date

Medicaid _____

NC Health Choice _____

Other Insurance: _____
Complete Verification of Pt.

Union County Division of Public Health
Notice and Consent to Financial Policies

Thank you for choosing Union County Division of Public Health (UCDPH) for your services. Please carefully review the 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 within "3" business days. Otherwise, I will be charged at 100%. I give permission for UCDPH to check household income and insurance coverage through employers and other sources as necessary to determine my eligibility for services. I will notify UCDPH 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 fees charged for such services are my personal responsibility. I also understand that fees charged by UCDPH may be adjusted due to income and that this adjustment does not apply to fees charged by other persons or entities outside of UCDPH.

Insurance. I will inform UCDPH if I have insurance now or if I should get insurance coverage in the future. Insurance co-payments are due at time of service. UCDPH 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 Medicaid, Medicare, or other insurance payment for services that I received through UCDPH is to be paid directly to UCDPH. I agree to pay to UCDPH any monies that I receive from any source that is sent directly to me as payment for services that I received at UCDPH. I will make this payment within 45 days of the day that I receive these monies.

Medical Release and Assignment of Benefits. I assign insurance benefits to Union County Division of Public Health (UCDPH). I understand that my signature will serve as legal "Signature on File" for purposes of filing my insurance claim. I authorize the release of any medical information as needed to process my claim. I agree to pay UCDPH any monies that I receive from any source that is sent directly to me as payment for services that were provided by UCDPH. UCDPH will file insurance claims for me; however I will pay on the balance or remaining balance if the insurance company does not pay within 60 days. I understand that UCDPH will confirm benefit coverage with my insurance company and that the information given is not a guarantee of payment. Benefits are subject to change depending on the time the claim is submitted.

Assessment and Payment of Fees. At each visit I will be charged an estimated fee for the services I received. However, if UCDPH fails to charge me the full amount of 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, and credit or debit card. My account will be charged a $20 returned check fee for any non-sufficient funds checks I write to the UCDPH. 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 $50.00 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 UCDPH 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 UCDPH and/or until all unpaid accounts with UCDPH are settled. I also understand that I may cancel this consent in writing and deliver it to UCDPH anytime during 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 Staff Signature/Union County Division of Public Health

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FINANCIAL ELEGIBILITY FOR UNINSURED PATIENTS

Number of Children_____ Number of Adults _____ Total Members in the Household_____

Household Unit Income

NAME	EMPLOYER OR SOURCE OF INCOME	HOW MUCH PAID WKLY/BI-W/HOUR	SOURCE OF DOCUMENTATION	GROSS ANNUAL INCOME

TOTAL HOUSEHOLD UNIT ANNUAL GROSS INCOME $_____

Explanations/Comments (Example: Unemployment, etc.)

_____

_____

_____

Eligibility Status: 40%_____ 60%_____ 80%_____ 100%_____

_____

Applicant's Signature Relation to Patient Date Signed

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METHODS OF PAYMENT ACCEPTED

Cash, Debit/Credit card (Visa, MasterCard)

INSURANCE ACCEPTED (Copay due at each dental appointment)

Medicaid/Health Choice ($3.00 copay)

BCBS, Aetna, United Health Care, Humana, Accumed

Cigna (Advantage is out of network)

Medcost (Contact Medcost prior appointment)

PROOF OF INCOME ACCEPTED

Dental Insurance Card

Pay Stubs (1) month / (2) bi-weekly / (4) weekly

Dental Clinic Employment letter

Social Security / SSI / Pensions / W-2 Forms

Income Tax Return (annual) / Alimony / Bank Statement / Disability

NC Unemployment / Military Earnings Statement

PROOF OF ID ACCEPTED

Valid State issued driver's license / Identification Card, Birth Certificate,

Department of Defense Identification Card, Student Identification Card, Passport,

Resident Alien Card or Matricula Consular Identification Card

***Authorization to Consent to Health Care of a minor Notarized (If applicable)**

***For safety reasons, children are not allowed in the room with adults for treatment.**

***Children are not allowed to be left unattended in the waiting areas.**

Last Name	First Name	MI

Patient SS#: _____

Date of Birth: ____/____/_____

NC Department of Health and Human Services
Public Health Nursing and Professional Development

PERMISSION TO USE AND DISCLOSE PATIENT HEALTH INFORMATION

I hereby acknowledge that I have received a copy of the "Notice of Privacy Practices" for Union 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 Union 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

Last Name First Name MI

Patient SS#: _____

Date of Birth: ___/___/_____

NC Department of Health and Human Services
Public Health Nursing and Professional Development

PERMISO PARA USAR Y DIVULGAR INFORMACION SOBRE SALUD DEL PACIENTE

Yo certifico que he recibido una copia del documento: "Aviso de Normas de Privacidad" de el Departamento de Salud del Condado/Distrito de Union y comprendo que puedo llamar a la persona citada anteriormente, si tengo alguna pregunta acerca del contenido de dicha información.

_____ _____
Paciente/Padres/Representante Legal Fecha

_____
Testigo

Yo doy mi consentimiento voluntario para que el Departamento de Salud del Condado/Distrito de Union utilize y divulgue la información médica/de salud del paciente:

_____
Nombre del paciente

con el propósito de tratamiento, pago y funciones de cuidado de salud.* Yo entiendo que la información de salud/médica utilizada y divulgada puede incluir información sobre enfermedades contagiosas (como el SIDA). Yo entiendo que puedo anular esta autorización en cualquier momento, con la excepción de acciones que hayan sido tomadas previamente basadas en este documento. Yo entiendo que este consentimiento es válido hasta que yo lo anule y que si quisiera anularlo debo hacerlo por escrito.

* Favor referirse al documento "Aviso de Normas de Privacidad" para definición de los términos "tratamiento", "pago", y "funciones de cuidado de salud".

_____ _____
Firma del paciente Fecha

_____ _____
Firma de padres, representante legal, o cualquier otra persona legalmente responsable (cuando exigido) Fecha

_____ _____
Testigo Fecha

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INFORMED CONSENT

Permission for Dental Examination and Treatment of an ADULT

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.

_____ _____

Patient Date

OR

Permission for Dental Examination and Treatment of a MINOR

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.

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

_____ _____

Parent/Legal Guardian of Patient Date

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SCHEDULING POLICY

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

1. All appointments require a **24 hour notice for cancellations** in order to be reappointed.

   If no notice is given and you do not show for your appointment it will be considered **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.

2. 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.

3. The Parent or Guardian of the child being treated may not leave the building for any reason.

   Thank you for your cooperation.

I have read the above written policies and comply

_____ _____

Patient / Parent/Legal Guardian Date

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. You may revoke such authorization at any time by notifying **Union County Division of Public Health, Attn: Privacy Officer, 2330 Concord Avenue, Monroe, NC 28110** in writing. If you revoke such authorization, however, it will not have any effect on actions taken by us in reliance on it.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

For more information concerning this Notice of Privacy Practices, contact **Union County Division of Public Health's Privacy Officer at 2330 Concord Avenue, Monroe, NC 28110 or 704-296-4800.**

Union County Department of Human Services
Division of Public Health
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The Union County Division of Public Health's mission is to prevent the spread of disease, protect the health of the community, and promote health.

UNION COUNTY DEPARTMENT OF HUMAN SERVICES DIVISION OF PUBLIC HEALTH

NOTICE OF PRIVACY PRACTICES

Effective: April 2003
Revised: March 2014
Revised March 2018

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Union County Division of Public Health collects and maintains health information about you and is required by law to protect the privacy of your health information. We are required to provide you with this Notice of Privacy Practices.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Your request must be made in writing and submitted to our Privacy Officer. In addition, you must provide a reason that supports your request.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- We may leave you a message or send you a letter concerning an appointment, lab results, or prescriptions, or to ask you to call us concerning you or your child's care or account unless you tell us otherwise. You can ask us to contact you in a specific way (for example, call your home or office phone or send mail to a different address).
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly or you may obtain a copy on our website at www.co.union.nc.us.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights.
- All complaints should be submitted in writing. To file a complaint with us, contact **Union County Division of Public Health, Attn: Privacy Officer, 2330 Concord Avenue, Monroe, NC 28110.** To file a complaint with the federal government, contact **Region IV Office for Civil Rights, US Department of Health and Human Services, Atlanta Federal Center, Suite 3B70, 61 Forsyth Street SW, Atlanta, GA 30303-8909** or visit **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Without your written permission, we will never sell or share your information for marketing purposes.

Some psychotherapy notes may be used in accordance with State and Federal laws.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.
- We can use your health information and share it with other professionals who are treating you.
- We can use and share your health information to run our practice, improve your care, and contact you when necessary.
- We can use and share your health information to bill and get payment from health plans or other entities.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety
- For proof of immunization to a school where State or other law requires the school to have such information prior to admitting the student
- For organ procurement organizations
- With a coroner, medical examiner, or funeral director when an individual dies
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services
- In response to a court or administrative order, or in response to a subpoena