GRAHAM COUNTY DEPARTMENT OF PUBLIC HEALTH
Dental Clinic

Registration

Print First, Middle, and Last Name _____

If pt. is under 18 years of age please list **parent/responsible party name:**_____

DOB of responsible party:_____ **Social Security number of responsible party:**_____

PLEASE CHECK THE FOLLOWING QUESTIONS REGARDING SEX & RACE

Sex:
☐ Male
☐ Female

Race : ☐ White ☐ American Indian ☐ Native Alaskan
☐ Hispanic ☐ Native Hawaiian ☐ Black
☐ Other Pacific Island ☐ Non-Hispanic ☐ Asian

Birth date: _____/_____/_____ Today's Date_____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Are you covered by Medicaid/Health Choice? ☐ Yes ☐ No

SSN#_____

Address (Mailing & Physical)_____

City_____ State _____ Zip Code _____

Home Phone: _____Work Phone: _____

Cell: _____ Email:_____

I understand my HIPAA rights and I request that this office leave messages for me with either of the two individuals listed below or by e-mail or voice mail at the numbers noted above. I understand that it is my responsibility to keep the practice informed of any changes to this information.

OTHER CONTACTS:

1. Name:_____ 2. Name:_____

Numbers:_____ Numbers:_____

Relationship:_____ Relationship:_____

GRAHAM COUNTY DENTAL CLINIC

CLIENT NO SHOW POLICY

Please read and initial each line

Clients of the dental clinic are allowed to have 2 no show events per calendar year without any repercussions. _____

If you fail to cancel your scheduled appointment less than 24 hours in advance you will be considered a no show. _____

If you are more than 15 minutes late for your scheduled appointment you will be considered a no show and may have to be reappointed. _____

After 3 no show events you will be sent a dismissal letter and your treatment will be limited to urgent care only for one year. _____

Clients with a history of broken appointments may not be allowed to schedule multiple family members on the same visit. _____

Signature _____ **Date**_____

(This policy has been enacted by health department leadership to improve customer satisfaction with wait times, as well as contribute to better utilization of county resources. The Graham County Health Dept. Dental Clinic thanks you for your cooperation with this policy)

Graham Co. Dental Clinic

21South Main St.
Robbinsville, NC 28771
Telephone # 828-479-7901
Fax # 828-479-7902

Statement for Patients: Collection and use of Social Security Numbers

Graham County Dental Clinic asks all patients to provide social security numbers, so that we have a means to uniquely identify each patient. Provision of your social security number is voluntary. Your social security number will be kept confidential in accordance with state and federal laws that protect the privacy of health information.

Graham County Dental Clinic is legally authorized to collect and use patient social security numbers for the following purposes:

- Determining whether patients are presumptively eligible for Medicaid (10A NCAC 22K.0102)
- Participating in the local government debt set-off program (G.S. 105A-3)
- The following activities, which require a unique identifier and are imperative to the performance of Graham County Department of Public Health/Graham County Dental Clinic's legally prescribed duties and responsibilities (G.S. 132-1.10):
    1. Uniquely identifying medical records
    2. Accessing or billing third-party insurance systems
    3. Submission of specimens to the state public health laboratory
    4. Newborn screening program
    5. Investigation and control of communicable diseases and other public threats
    6. North Carolina Immunization Registry
    7. Breast and Cervical Cancer Screening programs
    8. Arranging patients' participation in "purchase of care" programs, which help pay for health care
    9. Public health surveillance

I have read the above statement and voluntarily give my Social Security number to be used exclusively as stated.

_____ _____

Signature of client Date

_____ _____

Witness Date

Last Name First Name MI

Patient record#: _____

Date of Birth: ____/____/_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I am acknowledging that:

- I am either the patient or the patient's personal representative;
- I have received a copy of the "Notice of Privacy Practices" for _____ County/District Health Department; and
- I understand that I may contact the person named in the Notice if I have questions about the content of the Notice.

_____ _____

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

_____

Description of 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:

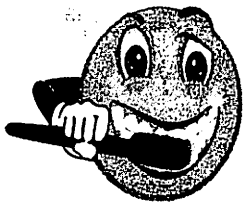
☐ Form mailed/sent to patient/personal representative on _____.
Date

Part 3. Complete if either Part 1 or Part 2 completed:

_____ _____

Signature of staff member Date

DHHS 3096 E (Revised 02/09
LTAT (Review 2/12)



Graham County Public Health
Dental Clinic

21 South Main Street
Robbinsville, NC 28771

Appointment/Conduct Policy

Clients must show up promptly for appointments and Emergency appointments must be here 15 minutes early for paperwork. If client cannot make appointed time, then they must call and reschedule 24 hours in advance. If the client fails to call, within 24 hours then this will be treated as a "no-show" appointment.

Clients will be allowed 2(two) opportunities per year to reschedule. If two reschedule opportunities are used within a year, you will only be seen for emergency appointments for one full year. After that one year, you will be seen for regular care.

If a client "No Shows" one time, that client will only be seen for emergency care for a full year. With the start of the New Year that client's normal care will resume.

Client Code of Conduct:

Clients accepted for treatment at the Graham County Public Health Dental Clinic must abide by certain rules of conduct while at the clinic:

1. **Offensive, rude, unsolicited comments and remarks are not tolerated**
2. **Verbal abuse**
3. **Physical abuse**
4. **Non Cooperative with staff**

These types of behavior are not acceptable, and will result in automatic client dismissal.

_____ _____

Signature of Client **Date**

****Remember it is very important to keep the Graham County Dental Clinic informed of your current contact information for reminders of appointments and cancellations.**

CONSENT FOR DENTAL EXAMINATION AND TREATMENT

1. I understand the dental staff will perform an oral examination on my child or myself and provide needed dental care on the dentists finding's. Dental treatments may include cleanings, fluoride, sealants, x-rays, fillings and extractions.
2. I understand that emergency dental treatment may be limited. Emergency procedures are generally done to relieve the patient from swelling, bleeding, infection and injury. Referrals to specialists or other facilities may be necessary.
    a) Upon signing this consent, I authorize Graham County department of Public Health Dental Clinic to release all necessary information contained in my dental chart to other facilities including but not limited to: dental specialists, orthodontists and surgical care centers in order to continue my dental care.
    b) Upon signing this consent, I authorize Graham County Department of Public Health Dental Clinic to share copies of Treatment Plans and Treatment Schedules with agencies such as Robbinsville 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.

3. 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.

4. I have been given the opportunity to have all my questions answered and agree to have myself or my child participate in the dental in the dental clinic program.

5. Parents are encouraged to be present in operatory room while treatment is rendered. It is our goal to develop good patient behavior and the Childs trust in the dental team.

6. I understand, that should my child be unable or unwilling to keep his/her head, arms, and or legs still, during a dental procedure, dental treatment cannot be safely provided. The child will be encouraged to sit still by using praise and explaining what the dentist is going to do. If the child is not able to sit still, the parent will be encouraged to reschedule in six months to one year. If the patient has a dental emergency and is not cooperative, he/she will be referred to another source of care.

7. I understand that the dental clinic is for children and adults who are eligible and receiving Medicaid, NC Health Choice and private pay. 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 Medicaid or NC Health Choice insurance, at the time of service I will be responsible for any expenses incurred during that visit.

8. I authorize the release of any dental information necessary to process any insurance claims. I authorize payment of dental benefits to the Graham County Department of Public Health Dental Clinic.

9. Should you fail to comply with the above stated responsibilities, the Graham County Department of Public Health Dental Clinic reserves the right to reschedule your visit, refer you to another practice, or dismiss you from our dental clinic.

10. We will schedule family members together for dental care in any day, to try to make it easier for families. However, it is the patient's responsibility to keep the appointments. If failure to keep appointments is a habit then the dental staff will not allow families to be scheduled together.

Printed Patient Name: _____ Signature of Patient: _____

Relationship to patient _____ Patients DOB: _____ Today's Date: _____