Today's Date: / /

Patient Information

Patient Name:

_____ _____
Last *First* *MI*

Date of Birth: _____/_____/_____

_____ _____
Street **Apartment #**

_____ _____ _____ _____
City **State** **Zip** **County**

Home Phone: _____-_____-_____
Cell Phone: _____-_____-_____
Work Phone: _____-_____-_____
Other: _____-_____-_____
Email Address: _____

Patient's Social Security #
_____-_____-_____

☐ Male
☐ Female

☐ Child ☐ Single
☐ Married ☐ Separated
☐ Divorced ☐ Widowed

Name of School Child Attends:
_____

RACE:
☐ Caucasian ☐ Black/African American
☐ Asian ☐ Native American
☐ Other : _____

ETHNICITY:
☐ Hispanic
☐ Non- Hispanic

PREFERRED LANGUAGE:
☐ English ☐ Spanish ☐ Other:_____

REFERRAL INFORMATION: *Who may we thank for referring you to our practice?*
☐ Friend ☐ Yellow Pages
☐ Family Member ☐ Flyer/Community Event
☐ CHA Staff Member ☐ Social Services (DSS)
☐ School or School Nurse ☐ CMC-NE Emergency Room
Community Health Center:
☐ China Grove ☐ McGill ☐ Logan
Cabarrus Health Alliance Department:
☐ Maternity Clinic ☐ WIC ☐ Pediatrics
☐ Centering Pregnancy ☐ Care Coordination 4 Children (CC4C)

PARENTS / LEGAL GUARDIAN (If patient is a child)

_____ **Social Security #**
Last **First** **MI**

_____ **Social Security #**
Last **First** **MI**

In my absence, the person who has my permission to bring my child to his/her dental appointment or approved to discuss my dental treatment with is: ******I understand that if my child's treatment plan is changed during this visit, his/her appointment may be rescheduled until treatment changes have been discussed with the parent and/or legal guardian******

NAME:	**RELATIONSHIP:**
NAME:	**RELATIONSHIP:**

INSURANCE INFORMATION **(Please check ☑ all that apply)** ☐ **Medicaid** ☐ **NC Health Choice** ☐ **Private**

Dental Insurance Company: _____
Phone # of Insurance Co: _____
ID #: _____
Employer Name: _____

Name of Policy Holder: _____
Policy Holder Date of Birth: _____/_____/_____
Policy Holder Social Security #: _____-_____-_____
Relationship to Patient: _____

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 (upon request) of the "Notice of Privacy Practices" for Cabarrus 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.

X _____ _____ _____
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 the 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

DHHS 3096 E (Revised 01/13) LTAT (Review 1/13)

CABARRUS HEALTH ALLIANCE

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280 Concord Pkwy S. Suite 110-A – Concord, NC 28027
Phone: 704-920-1070 Fax: 704-920-1071