SCHOOL CONSENT DENTAL SERVICES

Today's Date: / /

The Dental Program of Cabarrus Health Alliance will be serving your child's school to offer dental treatment. Your child will be seen during the school day. Your child will receive a note to take home to let you know exactly what was done that day and instructions for home care if necessary. The note will also state whether any additional treatment is needed. If you have any questions please call the Cabarrus Health Alliance appointment desk at **704-920-1070.**

If you would like the Cabarrus Health Alliance to provide your child's dental treatment, please sign the consent form below.

☐ **YES,** I consent for my child___________________________________, to receive **dental treatment, including a complete exam, x-rays, cleaning, fluoride, sealants, photographs, fillings and numbing medicine** provided by Cabarrus Health Alliance. I understand that dental treatment may be given to my child without my presence.

☐ **NO**, I do not consent for my child to receive treatment provided by the Cabarrus Health Alliance. (Other forms not required if you select "No")

PATIENT NAME:

_______________________________ Last Name   _______________________ First   ____ MI

Date of Birth: _____/______/________   ______________________________________ **Street Address**

Social Security #: _____- _____-_______

☐ Male ☐ Female   ____ **Apt #**   ___________________ **City**   ____ **State**   _________ **Zip**

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

ETHNICITY: ☐ Hispanic ☐ Non-Hispanic

PREFERRED LANGUAGE: ☐ English ☐ Spanish ☐ Other : ________

Name of School Child Attends: ____________________________

Home Phone: ______-______-_____

Cell Phone: ______-______-_____

Work Phone: ______-______-______

Other: ______-______-______

Email Address: ______________________________________

Does the patient have, or ever had any of the following conditions?
****Each question must be answered with a check ☑**

YES	NO		YES	NO		YES	NO	
☐	☐	ADD/ADHD	☐	☐	Epilepsy	☐	☐	Liver Disease
☐	☐	Anemia	☐	☐	Head Injury	☐	☐	Mumps
☐	☐	Artificial Joints	☐	☐	Hearing Loss	☐	☐	Pregnancy (NOW)
☐	☐	Asthma	☐	☐	Heart Trouble	☐	☐	Respiratory Problems
☐	☐	Bleeding Disorders	☐	☐	Heart Murmur	☐	☐	Seizures
☐	☐	Blood Disease/Sickle Cell	☐	☐	Hepatitis	☐	☐	Sexually Transmitted Disease
☐	☐	Cancer	☐	☐	High Blood Pressure	☐	☐	Stroke
☐	☐	Cerebral Palsy	☐	☐	HIV / AIDS	☐	☐	Teeth Grinding
☐	☐	Diabetes	☐	☐	Kidney Disease	☐	☐	Tobacco Use / Smoking
☐	☐	Down's Syndrome						

Have you ever had any serious illness not listed?
☐ **YES** ☐ **NO** ***If yes, please explain:*** _______________ _________________________________

Is the patient allergic to any of the following?
☐ **YES** ☐ **NO** ☐ Latex Products ☐ Anesthesia ☐ Penicillin ☐ Codeine ☐ Other ____________

Is the patient taking any medications? ☐ **YES** ☐ **NO**

Drug Name: ____________________ Taken For: ______________________

INSURANCE INFORMATION ☐ Medicaid ☐ Private
(Please check ☑ all that apply) ☐ NC Health Choice ☐ None

ID #: _________________________ Group #: ______________

Dental Insurance Company: ________________________

Phone # of Insurance Co: __________________________

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

Dental Clinic Financial Policy Information

Thank you for choosing Cabarrus Health Alliance (CHA). As a patient you should understand our fees, bills you are responsible for, and other financial policies as it applies to your dental care. We accept patients who have Medicaid, Health Choice, some private dental insurances and patients who are uninsured.

You are expected to pay your bill at the time of your visit. You may ask our patient representative to apply for our sliding fee scale payment plan that *may* qualify you to receive services at a reduced rate.

In the event we failed to bill for a procedure that was performed, we will bill you or your third party payor.

If you have Medicaid, Health Choice or private dental insurance we will bill them for your treatment. If you have an insurance co-payment, the co-pay is due at the time of your visit. Medicaid and Health Choice do not pay for every procedure you may need. You will be expected to pay for the treatment that is not covered by Medicaid and Health Choice and any charges that are not covered by your private insurance plan. However, you must pay your balance if your insurance does not pay us in 60 days. If you have questions or concerns with what your insurance plan covers or pays, please talk with your insurance company.

We will make a payment plan for anyone who has an outstanding balance; however you must talk to a patient representative before scheduling other visits if you cannot honor your payment plan. You will receive a bill for any charges that you are responsible for paying. You can pay with cash or check, money orders, credit cards, and debit cards.

I understand that if outstanding balances remain unpaid, the CHA has the right unless restricted by State or Federal regulations; to refuse or deny further services to you; submit your outstanding debt to the North Carolina Debt Setoff Collection Clearinghouse, pursuant to which qualifying debts may be automatically deducted from any State tax refund or lottery winnings you may be owed; and/or refer your account to a collection agency.

PARENTS / LEGAL GUARDIAN (If patient is a child)

____________________________ **Last**   ______________________ **First**   _____ **MI**   **Social Security #** _____/_____/__________

____________________________ **Last**   ______________________ **First**   _____ **MI**   **Social Security #** _____/_____/__________

X__________________________________ _______/_______/_________ ________________________________

Signature of parent or legal guardian   Date   Relationship to patient

CABARRUS HEALTH ALLIANCE

300 Mooresville Rd – Kannapolis, NC 28081
280 Concord Pkwy S. Suite 110-A – Concord, NC 28027
Phone: 704-920-1070 Fax: 704-920-1071