Today's Date: / /

Patient Name:

Last First MI

Date of Birth: / /

MEDICAL HISTORY

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		YES	NO	
☐	☐	ADD/ADHD	☐	☐	Down's Syndrome	☐	☐	HIV / AIDS	☐	☐	Rheumatic Fever
☐	☐	Anemia	☐	☐	Epilepsy	☐	☐	Kidney Disease	☐	☐	Seasonal Allergies
☐	☐	Arthritis	☐	☐	Fibromyalgia	☐	☐	Liver Disease	☐	☐	Seizures
☐	☐	Artificial Joints	☐	☐	Glaucoma	☐	☐	Mumps	☐	☐	Sexually Transmitted Disease
☐	☐	Asthma	☐	☐	Head Injury	☐	☐	Nervous Disorders	☐	☐	Stroke
☐	☐	Bleeding Disorders	☐	☐	Hearing Loss	☐	☐	Osteoporosis	☐	☐	Teeth Grinding
☐	☐	Blood Disease / Sickle Cell	☐	☐	Heart Trouble	☐	☐	Pink Eye/Conjunctivitis	☐	☐	Thyroid Problems
☐	☐	Cancer	☐	☐	Heart Murmur	☐	☐	Pregnancy (NOW)	☐	☐	Tobacco Use / Smoking
☐	☐	Cerebral Palsy	☐	☐	Hepatitis	☐	☐	Respiratory Problems	☐	☐	Ulcers
☐	☐	Diabetes	☐	☐	High Blood Pressure						

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

Does the patient have any of the following?
☐ appetite loss ☐ fever ☐ chest pain ☐ weight loss ☐ shortness of breath
☐ night sweats ☐ increased fatigue ☐ unexplained productive cough > 3 weeks

Is the patient allergic to any of the following?
☐ Latex Products ☐ Anesthesia ☐ Penicillin
☐ Codeine ☐ Other _____

		Is the patient taking any medications? ☐ YES ☐ NO	
		Drug Name:	**Taken For:**
☐ YES ☐ NO	**Has the patient been admitted to a hospital or needed emergency care during the past two years?**		
☐ YES ☐ NO	**Has the patient had any surgeries in the past? Explain**	1.	
☐ YES ☐ NO	**Has the patient ever had any complications following dental treatment?**	2.	
☐ YES ☐ NO	**Has the patient ever suffered any injuries to the mouth, head or teeth?**	3.	
☐ YES ☐ NO	**Is the patient physically, mentally, or emotionally impaired?**	4.	

CONSENT FOR TREATMENT

****PLEASE READ CAREFULLY****

1. **I request and authorize the dentist(s) of the Cabarrus Health Alliance Dental Program to perform any indicated diagnostic procedures, dental surgery, and/or dental treatment which is deemed necessary to diagnose and/or treat the condition(s) that have brought about my seeking care for this patient.**
2. **I understand that dental treatment may be limited in scope and is intended to provide relief from pain, swelling, infection or injury. I further understand that any additional treatment the patient may require following emergency/urgent care may not be available at the Cabarrus Health Alliance, and in that event, would need to be obtained elsewhere.**
3. **Prior to any treatment I will have had the opportunity to ask questions regarding the plan of treatment for this patient. I will also be informed of the potential risks associated with dental treatment (allergic reactions, aspiration, injury to oral structures, post-operative discomfort, temporary or permanent numbness, bleeding, and/or infection). I understand that these are the most common risks and are not necessarily all of the potential risks involved in treatment.**
4. **I understand that, if a child is uncooperative during dental procedures by movement of the head, arms, and/or legs, dental treatment cannot be safely provided. During such disruptive behavior, it may be necessary for the dentist/assistant(s) to hold the patient's hands, stabilize the head, and/or control leg movements. Behavior can also be guided by using praise, explanation, and demonstration of procedures and instruments; or using variable voice tone and loudness. If these measures do not result in the appropriate behavior, I understand that dental treatment of my child may be discontinued.**
5. **I understand children over the age of four can be seen without being accompanied by their parent or guardian. I am expected to wait in the dental clinic waiting area during his/her treatment.**
6. **All of my questions have been answered to my satisfaction, and I consent to the treatment and procedures planned. I understand that I may revoke this consent to treatment at any time and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated. I understand that if further questions arise about my child's treatment plan following the initial exam, I may call the clinic for further explanation. (704) 920-1070.**

***I have read and agree to the above six (6) items.**

X _____ _____/_____/_____ _____

Signature of patient, 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

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)

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Medical Release and Assignment of Benefits

Patient Name:

_____ _____ _____

Last *First* *MI*

Date of Birth: _____/_____/_____

I give permission for Cabarrus Health Alliance (CHA) to check income and insurance coverage through employers and/or other sources as necessary to determine my eligibility for services.

I give permission for CHA to release any medical information (including information regarding chemical dependency problems and/or treatment, HIV results, drug screen results and assessment), which is requested by Medicare, Medicaid, other insurance companies, or other agencies assisting in my care.

I authorize the Cabarrus Health Alliance and the applicable County Department of Social Services (e.g., Cabarrus, Mecklenburg, Rowan, etc.) to discuss information about me in the event I apply for financial assistance, including Medicaid. This information may include the following: date of application, application status, and the reason my application remains pending, any verification required to complete my application, the date and reason if denial (if applicable).

I understand that Medicare will only pay for services that are "reasonable and necessary for medical treatment and diagnosis" under section 1862 (a) (1) of the Medicare Law. I am personally responsible for any part of my bill not covered by Medicare, Medicaid or other insurance.

I understand that I may receive services or be referred for services provided by other physicians, laboratories, hospitals, or other agencies. I understand fees that other agencies charge are my personal responsibility. I also understand that fees are based on income at CHA, this adjustment does not apply to fees of persons or entities outside of the CHA.

I give permission for my picture to be taken and used to identify me and assist in my care. This is for CHA's use only and will not be released to any other source without my written permission.

I request that Medicaid, Medicare, or other insurance payment for services that I receive through CHA (including physician services) are to be paid directly to CHA. I agree to pay to Cabarrus Health Alliance any money that I receive from any source that is sent directly to me as payment for services that I have received from CHA. I will make this payment within 45 days of the day that I receive this money.

I understand that this consent will remain in effect while I am receiving care at CHA and/or until all unpaid accounts with CHA are settled. I also understand that I may cancel this consent in writing delivered to CHA anytime during CHA's normal business hours.

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.

(Please initial each line below to demonstrate that you understand our financial policies)

_____ I will notify CHA of any changes in my income for program services.

_____ I understand I am responsible for all charges.

_____ I agree for my insurance to pay Cabarrus Health Alliance Dental Clinic for dental care.

_____ I agree for Cabarrus Health Alliance Dental Clinic to give dental information to my insurance company if applicable.

_____ I have read the above information and have been able to ask questions. I have received answers to my questions and agree to comply.

INSURANCE/MEDICAID/HEALTH CHOICE

- Tell us if you have insurance now or when you start getting insurance coverage.
- If you have Medicaid and other insurance, Medicaid will pay ***after*** your other insurance pays.
- ***If you do not tell us about other insurances, Medicaid will not pay.**
- **You** must pay your bill if we are not a provider for your insurance plan.
- You **must** show a current Medicaid, Health Choice or private insurance card at each visit.
- If you do not have proof of current coverage you may be asked to pay the charges for the visit.
- Clients bringing in their Medicaid and/or insurance card after date of service must do so within a time frame that payors allow for billing of the service.

X _____ _____/_____/_____

Signature of patient, parent or legal guardian Date

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