Macon County Health Department
Dental Clinic
PATIENT REGISTRATION

ID: ______ Chart ID: ______

First Name: ______ Last Name: ______ Middle Initial: ______

Patient Is: ☐ Policy Holder Preferred Name:
☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: ______ Last Name: ______ Middle Initial: ______

Address: ______ Address 2: ______

City, State, Zip: ______ Pager: ______

Home Phone: ______ Work Phone: ______ Ext: ______ Cellular: ______

Birth Date: ______ Soc Sec: ______ Drivers Lic: ______

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: ______ Address 2: ______

City: State / Zip: Pager: ______

Home Phone: ______ Work Phone: ______ Ext: Cellular: ______

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: ______ Age: ______ Soc. Sec: ______ Drivers Lic: ______

E-mail: ______ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: ______ Pref. Dentist: ______

Employer ID: ______ Pref. Pharmacy: ______

Carrier ID: ______ Pref. Hyg.: ______

Section 3

11: ______

Primary Insurance Information

Name of Insured: ______ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: ______ Insured Birth Date: ______

Employer: ______ Ins. Company: ______

Address: ______ Address: ______

Address 2: ______ Address 2: ______

City,State,Zip: ______ City,State,Zip: ______

Rem. Benefits: .00 Rem. Deduct: .00

Secondary Insurance Information

Name of Insured: ______ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: ______ Insured Birth Date: ______

Employer: ______ Ins. Company: ______

Address: ______ Address: ______

Address 2: ______ Address 2: ______

City,State,Zip: ______ City,State,Zip: ______

Rem. Benefits: ______.00 Rem. Deduct: ______.00

Macon County Health Department
Dental Clinic

MEDICAL HISTORY

PATIENT NAME ______________________________ Birth Date ______________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: ______________________

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ______________________

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ______________________

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ______________________

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ______________________

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No ______________________

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
- ☐ Pregnant/Trying to get pregnant?
- ☐ Nursing?
- ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Sulfa Drugs

☐ Other If yes, please explain: ______________________

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Hypoglycemia	☐ Rheumatic Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Irregular Heartbeat	☐ Rheumatism
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Kidney Problems	☐ Scarlet Fever
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Leukemia	☐ Shingles
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Liver Disease	☐ Sickle Cell Disease
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Low Blood Pressure	☐ Sinus Trouble
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pacemaker	☐ Lung Disease	☐ Spina Bifida
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Mitral Valve Prolapse	☐ Stomach/Intestinal Disease
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Osteoporosis	☐ Stroke
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Psychiatric Care	☐ Tonsillitis
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Radiation Treatments	☐ Tuberculosis
☐ Cancer	☐ Frequent Cough	☐ High Cholesterol	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hives or Rash	☐ Renal Dialysis	☐ Ulcers
				☐ Venereal Disease
				☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: ______________________

Comments: ______________________

____

____

____

____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______________________ DATE ______________

OFFICE POLICIES

MACON COUNTY DENTAL CLINIC

1. Medical card recipients must have their medical card at the time of their appointment. Without it, we may have to reschedule your appointment.
2. All patients paying with cash must pay for the services provided at the time the services are rendered.
3. If you are more than 15 minutes late for your appointment, you may be rescheduled to the next available appointment
4. Children 17 and under must be accompanied by a responsible adult.
5. Children under the age of 12 may not be left alone in the waiting room while the parent is in the treatment area for another child's appointment or for their own appointment.
6. **PLEASE CALL AND CANCEL YOUR OR YOUR CHILD'S APPOINTMENT IF YOU ARE UNABLE TO KEEP IT. AFTER THREE NO SHOWS, YOUR APPOINTMENT MAY NOT BE RESCHEDULED.**
7. We will do everything we can to protect your privacy regarding you or your child's appointment and treatment. If you have special requests for privacy, please let us know.
8. We try our best to complete treatment that we initiate in our office on all patients. However, if you (as the patient) or your child (as the patient) is unable to tolerate a procedure to its completion or an unforeseen circumstance arises that prohibits us from completing the treatment we will provide you recommendations for completing treatment. It is your responsibility to follow up with our recommendations and to seek additional care for yourself or your child.

Patient or parent / guardian signature: ____

Date Signed: ____

Family and Friends Involved in Your Care or Your Child's Care

Patient's Name (Child's) ____

Patient's (Child's) Date of Birth ____

Macon County Health Department Dental Clinic is committed to protecting your privacy.

Please list who we may discuss your treatment information with and who may bring your child to his/her dental appointments.

Name	**Relationship to Patient**	**Phone number**

Anyone listed above must show their ID so we may verify their identity.

Please provide a phone number where you can be reached with any *immediate* concerns or questions ____

Patient's Signature (if this form is for yourself) ______________________________________

Parent's Name Printed ____

Parent's Signature ____

Today's Date _______________________ Effective Through Date ____________________
(not to exceed one year)

CONSENT FOR TREATMENT

MACON COUNTY DENTAL CLINIC

PATIENT'S NAME:___________________________ DOB:_________________

I HEREBY AUTHORIZE THE MACON COUNTY DENTAL CLINIC DENTISTS AND STAFF TO PERFORM DENTAL TREATMENT ON THE ABOVE NAMED PATIENT.

I REQUEST AND AUTHORIZE THEM TO DO WHATEVER THEY DEEM ADVISABLE IF ANY UNFORESEEN CONDITION ARISES IN THE COURSE OF TREATMENT, CALLING IN THEIR JUDGEMENT, FOR PROCEDURES IN ADDITION OR DIFFERENT FROM THOSE NOW CONTEMPLATED.

I CONSENT TO THE ABOVE TREATMENT AFTER HAVING BEEN ADVISED OF THE RISKS, ADVANTAGES, AND DISADVANTAGES OF THE TREATMENTS AND THE CONSEQUENCES IF THIS TREATMENT WERE WITHHELD.

I CONSENT TO THE ABOVE TREATMENT PLAN AFTER HAVING BEEN ADVISED OF THE ALTERNATE PLANS OF TREATMENT AVAILABLE AND THE KNOWN MATERIAL RISKS, ADVANTAGES, AND DISADVANTAGES OF THE ALTERNATIVE TREATMENT.

I FURTHER CONSENT TO THE ADMINISTRATION OF LOCAL OR GENERAL ANESTHESIA, ANTIBIOTICS,ANALGESICS, OR ANY OTHER DRUGS THAT MAY BE DEEMED NECESSARY IN MY CASE, AND UNDERSTAND THAT THERE IS A SLIGHT ELEMENT OF RISK INHERENT IN ADMINISTRATION OF ANY DRUG OR ANESTHESIA. THIS RISK INCLUDES ADVERSE DRUG RESPONSE (E.G. ALLERGIC REACTIONS), CARDIAC ARREST AND ASPIRATION, AND THROMBOPHLEBITIS (E.G.IRRITATION AND SWELLING OF VEIN), PAIN DISCOLORATION AND INJURY TO BLOOD VESSELS AND NERVES WHICH MAY BE CREATED BY INJECTIONS OF ANY MEDICATIONS OR DRUGS.

I AM INFORMED AND FULLY UNDERSTAND THAT INHERENT IN ANY TYPE OF SURGERY ARE CERTAIN UNAVOIDABLE COMPLICATIONS. IN ORAL SURGERY, THE MOST COMMON OF THESE COMPLICATIONS INCLUDE POST-OPERATIVE BLEEDING, SWELLING OR BRUISING, DISCOMFORT, STIFF JAWS, LOSS OR LOOSENING OF DENTAL RESTORATIONS. LESS COMMON COMPLICATIONS CAN INCLUDE INFECTION, LOSS OF INJURY TO ADJACENT TEETH AND SOFT TISSUE, NERVE DISTURBANCES (E.G.NUMBNESS IN THE MOUTH AND LIP TISSUE). JAW FRACTURES, SINUS EXPOSURE AND SWALLOWING OF ASPIRATION, TEETH AND RESTORATIONS, AND SMALL ROOT FRAGMENTS REMAINING IN THE JAW WHICH MIGHT REQUIRE EXTENSIVE SURGERY FOR REMOVAL.

I REALIZE THAT IN SPITE OF THE POSSIBLE COMPLICATIONS AND RISKS, THE CONTEMPLATED SURGERY/TREATMENT IS NECESSARY AND DESIRED BY ME. I AM AWARE THAT THE PRACTICE OF DENTISTRY AND SURGERY IS NOT AN EXACT SCIENCE AND I ACKNOWLEGE THAT NO GUARANTEES HAVE BEEN MADE TO ME CONCERNING THE RESULTS OF THE OPERATION OR PROCEDURE.

I HAVE PROVIDED AS ACCURATE AND COMPLETE MEDICAL AND PERSONAL HISTORY AS POSSIBLE INCLUDING THOSE ANTIBIOTICS, DRUGS, MEDICATIONS AND FOODS TO WHICH I AM ALLERGIC. I WILL FOLLOW ANY AND ALL INSTRUCTIONS AS EXPLAINED AND DIRECTED TO ME AND PERMIT PRESCRIBED DIAGNOSTIC PROCEDURES.

PATIENT OR GURARDIANS SIGNATURE:___________________________ DATE:_________________

CONSENT AND ACKNOWLEDGMENT

RECEIPT OF NOTICE OF PRIVACY PRACTICES
MACON COUNTY HEALTH DEPARTMENT

Patient Name: ___________________________________ Patient Date of Birth: ___________________

Parent/Guardian/Caretaker Name (if different than patient): ____

Names of other family members receiving care from the Macon County Health Department:

Name: ____ Date of Birth: ________________________

Name: ____ Date of Birth: ________________________

(continue on back if needed)

I do hereby consent to allow the Macon County Health Department and its designated employees and contractors to provide health care and/or health care related services to me and/or my family.

I understand that the nature and consequences of any services and/or procedures provided or performed will be explained to me.

I understand that the Macon County Health Department is already authorized to use the information gained during treatment to bill me, my insurance company, or any other potential sources of reimbursement, such as government programs in which I am enrolled or qualify for services.

I also hereby acknowledge that I received a copy of the "Notice of Privacy Practices" from the Macon County Health Department dated April 14, 2003 and revised September 23, 2013.

____ _________________________

Signature of Parent/Guardian Date Signed

Check if any of the following apply:

______ Parent or Guardian of Minor
______ Guardian with power to make health care decisions
______ Power of Attorney for Health Care
______ Mental Health Treatment Preference Declaration Agent
______ Health Care Surrogate

Staff Use Only

The Macon County Health Department was unable to obtain the Acknowledgment because:

______ Patient Refuses to Sign ______ Other (Specify) ____________________________________

______ Employee Initials Date_______________

Place Acknowledgment in client's chart or medical record.