Douglas County Dental Clinic Patient Registration

Revised August 2016

We REQUIRE A Parent, Guardian, Or Other Legally Responsible Party To Complete & Sign all forms. Please provide a photo ID, Proof of Douglas County Residency & Proof of Income (see below)

Patient Information

Patient's Legal Name: _____ Preferred Name: _____
First Middle Last

Date of Birth: _____ Age: _____ Gender: _____ Social Security #: _____

Address: _____ Apt. or Lot #: _____

City: _____ State: _____ Zipcode: _____ County: _____

Home (____)_____ Cell (____)_____ Work (____)_____

E-mail address: _____

Is anyone in the household a migrant or seasonal farm worker? ☐Yes ☐No

Insurance Information (please present card with paperwork)

KanCare / Medicaid #_____ Sunflower **/** Aetna **/** United Healthcare (circle one)

☐ Ryan White # _____ Private Insurance: _____

☐ Voc Rehab ☐ No Insurance Policy Holder Name: _____ DOB: _____

Policy Holder SSN: _____

Any other type of dental benefits not listed? If yes, what? _____

Parent/Guardian Information

Name: _____ Relationship to Patient: _____

Home Phone: (___)_____ Cell: (___)_____ Work Phone: (___)_____

Address: _____ City: _____ State: _____ Zip: _____

Name: _____ Relationship to Patient: _____

Home Phone: (___)_____ Cell: (___)_____ Work Phone: (___)_____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact

Name: _____ Relationship to Patient: _____

Home Phone: (___)_____ Cell: (___)_____ Work Phone: (___)_____

Household Income Information

Supporting documentation is REQUIRED for income for all persons in the patient's household over age 18. If the patient is a child with Medicaid insurance, income documentation is not required. Please provide all applicable documents:

☐ **Previous Years Income Tax Return** ☐ **Grants/Student Loans**

☐ **Social Security Disability/Income/Benefits** ☐ **Support from family/friends (if no income)**

How many people are dependent on the this income? _____

If no income is reported, how is the household supported?:_____

I certify that the information provided is true and correct to the best of my knowledge. I will supply updated information to Douglas County Dental Clinic if my financial and/or insurance benefits change. I understand that failure to disclose these changes, falsify information, or failure to provide proof of income may result in discontinuation of services at the Douglas County Dental Clinic. I consent to the release of information on this form to appropriate agencies and funding sources to verify income.

_____
Patient's Name (Printed)

_____ _____
Date

Office Use Only: Fee Level _____

Signature of: ☐Patient ☐Parent ☐Legally Responsible Party

Health History

Reason for visiting the clinic today:_____ How long have you had the problem?_____

When was your last dental visit? _____ Where? _____

Please rate your pain on a scale of 1-10: (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Extreme pain)

Do you have any food or medication allergies? _____

Please list allergies:_____

Are you allergic to latex? _____

Have you ever had a reaction to local anesthetic?_____

List any prescription or nonprescription medications you are taking:

Medication	Amount	Frequency

What pharmacy do you prefer? _____

Do you smoke tobacco? Y N Do you drink alcohol? Y N Do you use smokeless tobacco? Y N Do you use recreational Drugs? Y N

Do you have a medical doctor? Y N Doctor's Name:_____

If not, where do you go for health care? Health Care Access Heartland Hospital/ER Other

When was your last physical exam?_____

How many times in the last year have you been treated in the hospital ER?_____

Do you have a history of any of the following? (Please circle all that apply):

Blood or blood clotting disorders	Stroke	Prosthetic joints or heart valves
Kidney disease	HIV/ AIDS	Asthma
Prolonged Bleeding	Persistent cough	Seizures
Aspirin Therapy	Emphysema	Chemical Dependency
Thyroid disease	Stomach/intestinal problems	Anxiety
Hardening of the arteries	Diabetes	Fainting/Dizziness
Chest Pain	Anemia	Latex Allergy
Swollen Ankles	Liver disease	Steroid Medication
High blood pressure	Hepatitis	Organ Transplant
Heart problems	Urinary tract problems	Depression
Heart murmur	Difficulty urinating	Chronic Mental Illness
Mitral Valve Prolapse	Frequent headaches	Arthritis
Rheumatic heart disease or fever	Shortness of Breath	Glaucoma
Chemotherapy or radiation therapy	Seasonal Allergies	Ear, Nose or Throat Problems
Stent	Skin diseases	Osteoporosis
Sexually transmitted disease	Cancer	Tuberculosis

Bisphosphonate medication (e.g. Bonefos, Reclast, Skelid, Zoledronate (Zometa), Pamidronate (Aredia), Alendronate (Fosamax), Risedronate (Actonel), Etidronate (Didronel), Ibandronate (Boniva))

Are you pregnant? Y N Nursing? Y N Post-menopausal? Y N Taking birth control pills? Y N

Do you have any disease, condition or problem not listed? Y N

If yes, please explain:_____

_____

Patient's Name (Printed)

_____ _____

Date

Signature of: ☐Patient ☐Parent ☐Legally Responsible Party

Douglas County Dental Clinic

Treatment Policy

1) I understand that I may receive services at Douglas County Dental Clinic only if I qualify for services. In order to see if I qualify for service I must present proof of income, photo ID, and proof of Douglas County residency.
2) I agree to pay for the services I receive according to Douglas County Dental Clinic's sliding scale.
3) I understand payment is due at the time of service and that no future appointments can be made until my balance is paid in full.
4) I understand that DCDC may increase fees annually as operating costs increase.
5) I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me as to the results of examination and treatment at Douglas County Dental Clinic.
6) I understand that I must provide true and complete information when completing forms.
7) I understand the importance of my health history and affirm I have given any and all information that may impact my care. I understand that failure to give true and complete health information may adversely affect my care and lead to unwanted complications. I will inform the dentist or hygienist of any changes to my health or medications at each appointment before treatment begins.

8) I understand that the Douglas County Dental Clinic is not responsible for any bills incurred outside of the services it provides for me, such as emergency room visits, medications or supplies.
9) I understand that a parent, guardian, or legally responsible party must accompany children under 18 years of age, and must be present at the clinic for the duration of an appointment. If someone other than a parent, guardian, or legally responsible party accompanies a child, he/she must bring in a signed statement from the parent, guardian, or legally responsible party allowing the person transporting the child to make medical decisions on behalf of the patient (ie. a consent to medical care).

10) I understand that if I do not arrive within 15 minutes of the scheduled appointment time, another appointment may have to be made and this will constitute a missed appointment.
11) I understand that not showing up for an appointment may result in the cancellation of all other scheduled appointments.

12) I understand that the Douglas County Dental Clinic staff can permanently dismiss me and my family members at their discretion. Reasons for dismissal may include but are not limited to the following:
    - Missed appointments without calling to cancel 24 hours in advance.
    - Threatening, inappropriate, or abusive behavior while interacting with staff.
    - Not following the dentist's advice that has been given to benefit the patient's health.
    - Failure to provide true and complete information.
    - Not showing up for, or canceling without 24 hours' notice, an appointment with a provider we refer you to.
13) I understand that dismissal means denial of future services at the Douglas County Dental Clinic. We will forward your records to another office at your request and can provide emergency treatment for 30 days after the dismissal is issued.
14) I consent to sharing of my health information with other health care providers as needed to facilitate my care.
15) I understand that Douglas County Dental Clinic staff are required by law to report any suspicion of child or adult abuse, including neglect or emotional, physical or sexual abuse.
16) I consent to have blood tests in the event of exposure of a Douglas County Dental Clinic staff member to my blood or bodily fluids. Douglas County Dental Clinic agrees to pay for the testing it requests. Testing will be performed by the provider of Douglas County Dental Clinic's choice.

17) I authorize Douglas County Dental Clinic to take permanent possession of any extracted teeth and/or tissues and retain or dispose of these specimens in any manner whatsoever.
18) I have read and fully understand the statements above or someone has clarified to me anything I did not understand. I agree to the terms stated here and I willingly provide information about myself in order to receive care.
19) **I consent to dental evaluation and treatment by staff and licensed volunteers of Douglas County Dental Clinic, including dental students and dental hygiene students.**

_____ _____

Patient's Name (Printed) Patient's Date of Birth

_____ _____

Signature of: ☐Patient ☐Parent ☐Legally Responsible Party Today's Date

Consent to Care

_____

Patient's Name (Printed)

I wish to allow the following individual(s) access to my protected health information. I understand that I can revoke this at any time in writing to Douglas County Dental Clinic.

_____	_____	_____
Name	Relationship	Phone #
_____	_____	_____
Name	Relationship	Phone #

******If patient is a MINOR - please list below any person that may bring the minor child into the clinic for care.******

_____	_____	_____
Name	Relationship	Phone #
_____	_____	_____
Name	Relationship	Phone #

_____ _____

Signature of: ☐Patient ☐Parent ☐Legally Responsible Party **Today's Date**

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I have been made aware of this office's Notice of Privacy Practices.

A copy is available on the clinic's bulletin board for me to read.

_____ _____

Signature of: ☐Patient ☐Parent ☐Legally Responsible Party **Today's Date**

Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)

DCDC Financial Agreement

I. FINANCIAL POLICY

1. Patients WITH Insurance Coverage:

° Please understand that your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will be glad to help you obtain the appropriate benefits from your insurance carrier as a courtesy to you. However, you are responsible for understanding your individual benefits and for the payments of your account.

° Regarding insurance plans where we are a participating provider, all co-pays and deductibles are due prior to or at the time of the treatment.

° Regarding insurance plans where we are NOT a participating provider, estimates will be collected prior to or at the time of the treatment and difference will be billed as necessary.

° If your insurance company has not paid the claim within 60 days, the balance will be automatically transferred to you.

° In some cases, insurance carriers may pay for alternative benefits other than the treatment performed and impose frequency limits on procedures your dentist may recommend. In these cases, you are responsible for the costs insurance does not pay.

° Even if you have dual coverage there may still be a portion that is your responsibility.

2. Patients WITHOUT Insurance Coverage:

° Patients without insurance coverage are required to pay in full for services rendered at or prior to the time of treatment.

° Crown and root canal therapy treatment: Patients are required to pay 50% of their associated fee at time of scheduling the appointment. If the patient fails to arrive for the scheduled appointment, cancels or reschedules with less than one business day notice, this fee is non-refundable. The remainder of the fee will be due at time of service.

II. CANCELLATION POLICY

° We require a cancellation notice one business day prior to the scheduled appointment.

° Patients who fail to show for their scheduled appointment without giving due notice will have remaining scheduled appointments canceled and be at risk of permanent dismissal.

III. BILLING POLICY

° Checks returned unpaid from the bank are subject to $20.00 service fee.

° Patients carrying a balance on their account will not be allowed to schedule future appointments until the balance is paid in full.

IV. ACKNOWLEDGEMENT OF UNDERSTANDING

° I understand it is my responsibility to know the benefits and limitations of my insurance coverage.

° I understand that some services recommended my dentist, including but not limited to: x-rays, fluoride, exams and sealants, may have frequency li placed by my insurance. I understand I will be responsible for the costs of these services should my insurance not pay for them.

We accept Cash, Check, MasterCard, Visa, and Discover, or Debit/ATM cards. *We are happy to answer questions regarding insurance plans and payment policies.*

BY SIGNING, I AGREE I HAVE READ AND UNDERSTAND DOUGLAS COUNTY DENTAL CLINICS FINANCIAL POLICY, CANCELLATION POLICY AND BILLING POLICY AND THAT I AM THE PERSON RESPONSIBLE FOR THIS PATIENT'S ACCOUNT.

Patient's Printed Name: _____ Date: _____

Patient or Parent/Guardian Signature: _____