Pender County
Health Department

...Building a healthier tomorrow…

Carolyn Moser, BSN, MPA
Health and Human Services Director

PENDER COUNTY DENTAL CLINIC
803 S. Walker St. Burgaw NC 28425
Phone (910) 259-1503
Fax (910) 259-1511
HOURS M-TH 8:30AM – 4:00PM

Thank you for choosing the Pender County Health Department Dental Clinic for your dental needs. Our goal is to provide the public with quality dental care with lower, more affordable cost. Improving and maintaining your oral health is our top priority.

In order to maximize your time with us, we ask you have the following at the time of your appointment:

- ✓ Completed medical history form
- ✓ List of your current medications
- ✓ Completed patient information form
- ✓ Current photo ID
- ✓ Insurance information and card
- ✓ Completed eligibility form with proof of income, if qualifying for a discount
- ✓ Any information or radiographs from your previous dentist must be received **prior** to your appointment

Arriving to your appointment without any of the requested items could cause a delay in your treatment.

We require fees to be paid at the time of service.

Thank you for your cooperation,

Pender County Dental Clinic Staff

Revised March 1, 2023

REGISTRATION FORM

PATIENT INFORMATION: Today's Date: _____

Last Name: _____First Name: _____Middle Name: _____

Date of Birth: _____ AGE: _____ SEX: F □ M □ STATUS: Single □ Married □ Divorced □ Widowed □
RACE: □ Caucasian □ Asian □ Native Hawaiian □ American Indian □ Black or African American □ Other
ETHNICITY: □ Asian □ Hispanic □ Non-Hispanic □ Middle Eastern □ Other
Preferred Language: _____

"**BEST**" Phone Number to Call: _____ Other Phone Number: _____
Address: _____
City: _____ Zip:_____ County: _____
Email Address: _____

Employer:_____ SS#: _____

IN CASE OF EMERGENCY I AUTHORIZE YOU TO CONTACT:

Last Name: _____ First Name: _____
Relationship: _____ Phone Number: _____

INSURANCE INFORMATION:

□ **AUTHORIZATION TO BILL INSURANCE COMPANY:**
I certify that I, and/or my dependent(s), have insurance coverage with:
Insurance carrier: _____ ID # or SS# of Subscriber: _____
Subscribers Name: _____ Subscribers Date of Birth: _____

I assign directly to Pender County Health Department Dental Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named clinic may use my health care information and may disclose such information to the above named insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

□ **NO INSURANCE AND I AGREE TO PAY AT TIME OF SERVICE**

SIGNATURE OF PATIENT OR REPRESENTATIVE **DATE**

PLEASE PRINT NAME OF PATIENT OR REPRESENTATIVE **DATE**

Revised March 1, 2023

Pender County Health Department Dental Clinic

Form 023: Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I am acknowledging that I have been provided with a copy of **Pender County Health Department Dental Clinic's** Notice of Privacy Practices dated December 1st, 2009 pursuant to the Health Information Portability and Accountability Act of 1996 (HIPAA).

Signature of Patient (or Representative)	Date
Printed name of Patient	Printed name of Representative
	Relationship to Patient

Evidence of the authority of the patient's representative must be attached to last page of this acknowledgement.

If patient is unable to sign please document the reason and initial: _____

- I hereby give Pender County Health Department Dental Clinic permission to leave messages on my telephone answering machine or to whomever answers the telephone.
- I hereby give Pender County Health Department Dental Clinic permission to give information about my health and/or medical condition to the person(s) listed below:

NAME	RELATIONSHIP

Signature of Patient (or Representative)	Date

PENDER COUNTY DENTAL

APPOINTMENT POLICY

We, as members of the Pender County Dental Clinic, are committed to provide our clients with the highest quality dental care at extremely affordable fees. Because the cost to operate and provide dental services is significant, we require your support and cooperation to enable us to keep our fees as low as possible.

We understand that sometimes circumstances arise that prevents patients from keeping their appointments. If you need to change or cancel your appointment, **please give us a call at least 24 hours in advance**. With this prior notice, we can reschedule your appointment and let another patient have the appointment time originally reserved for you. **If you are more than **15 minutes** late for your appointment you will be rescheduled and it is considered a missed appointment.

Any unconfirmed appointments will be cancelled 24 hours prior to your appointment. We will make every effort to reach you for confirmation, but it is the patient's responsibility to ensure appointments are confirmed with the office. **Please make sure you keep your contact information up to date with our office.**

Our policy for missed appointments is as follows:

- **1 missed appointment**: A courtesy letter is sent to inform the patient of our policy.
- **2 missed appointments**: A letter is sent informing the patient that they have missed 2 appointments and if one more appointment is missed then we will no longer be able to schedule appointments on a specific day.
- **3 missed appointments**: A letter is sent informing the patient that they have missed 3 appointments and we can no longer set scheduled appointments for you. The patient is now on the "walk-in" only appointment list for scheduling. Which means, when an appointment is needed the patient will have to call the clinic first thing in the morning and see if there is an available appointment that day. We will be happy to see the patient if the scheduling allows.

**Pender County Dental will not deny anyone emergency care. If you are having a true emergency please call the office and we will do our best to fit you in our schedule that week.

Please sign below that you have read and understood the Pender County Dental Appointment Policy:

Signature of Patient or Representative Date

Name of Patient

Revised March 1, 2023

PENDER COUNTY HEALTH DEPARTMENT DENTAL CLINIC
803 S. WALKER STREET
BURGAW, NC 28425
910-259-1503

I, _____, consent to be a patient at the Pender County Dental Clinic and agree to a radiographic and clinical examination.

***Please initial below that you understand and consent to the following:**

_____I understand that the Pender County Dental Clinic's dentist is adjunct faculty for UNC School of Dentistry, and students or residents may be performing my treatment under the supervision of the health department dentist. The Pender County Dental Clinic's hygienist also works with Cape Fear Community College and Coastal Carolina Community College and students may be performing my treatment under the supervision of the health department hygienist.

_____During treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography and photography.

_____I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

_____No guarantees can be made about treatment outcomes, restoration longevity, or prognosis. I understand that any branch of medicine, including dentistry, is not an exact science and can involve unanticipated results.

_____I will pay in full any cost of treatment or insurance co-payments according to the office's financial policy. I understand that even if insurance provides an estimate or a procedure has been pre-approved, I am responsible for *any* and all costs that my insurance does not cover.

_____My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

_____I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Print Name of Patient or Child Date

Patient Email and Text Messaging Registration Form

Due to the changing world of healthcare and technology, Pender County Dental Clinic has the ability to provide our patients with certain types of information via email and/or text messaging. If you wish to have the opportunity to receive information of this type, please complete the form below.

Pender County Dental Clinic strongly believes in protecting the privacy of our patients. When you provide this information to us, it is only used to communicate with you. To protect your privacy, no confidential or personal information will be sent from Pender County Dental Clinic via email or text messaging. Pender County Dental Clinic does not share the names, email addresses, and/or cell phone numbers of patients with any other company, or with any other patient. Please update your contact information with us at each visit. Declination can be made at anytime by notifying the office.

Please print all information neat and legibly.

Name_____

Email_____

Cell Phone_____

_____ Yes, please sign me up to receive **email and text** message confirmations.

_____ I do not wish to be contacted via email. (**Text messaging only**)

_____ I do not wish to be contacted via text messaging. (**Email only**)

_____ I **do not wish** to be contacted by **either** text messaging or email.

I hereby give Pender County Dental Clinic permission to send messages to me via email and or text as a means of communication as indicated by my selection.

_____ _____

Signature Date

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DENTAL HISTORY

What is the reason for your visit today? _____

Have you or a member of your family been here or to the mobile clinic before? _____

Who?_____

When was your last dental cleaning? _____

If in pain, which area of your mouth hurts? _____

How long has it been bothering you? _____

Does anything make the pain better or worse? _____

How frequently do you visit a Dentist? _____ per year

What was the reason for your last dental visit? _____

Have you had radiographs taken at another office recently? **YES NO**
*If you have had radiographs recently at another office, please be aware that you will need to request them to be sent to us via email **prior** to your appointment to avoid over-exposure and denied insurance claims.*

How often do you brush? In the morning / At night / Both

How often do you floss? _____Per day

Difficulty with prior dental treatment? **YES NO** Why? _____

Previously prescribed antibiotics *prior* to dental treatment? _____

Consumption of carbonated beverages / Sweets? **YES NO**

What? _____

Oral Habits (clench/grind/nail biting): _____

Past/ Present Tobacco Use? Frequency? _____

Past/ Present Alcohol Use? Frequency? _____

Past/ Present Recreational Drug Use? Frequency?_____

HEALTH HISTORY

Patient Name: _____ **Date of Birth**: _____ **Height**: _____ **Weight**: _____

Medical Doctor's Name: _____Last seen on: _____ Phone: _____

Pharmacy: _____Phone: _____

Have you been **hospitalized** for serious illness or injury? If so please explain:_____

_____

PLEASE CIRCLE ANY CONDITIONS THAT YOU HAVE OR HAVE HAD:

Skin: ☐ YES ☐ NO
Eruptions / Rash / Hives
Frequent cold sores / Fever blisters
Other: _____

Eyes/Ears: ☐ YES ☐ NO
Blurred vision / Glaucoma
Hearing loss / Ringing in ears / Pain in ears
Other: _____

Respiratory: ☐ YES ☐ NO
Difficulty breathing / Shortness of breath
Sleep Apnea / Snoring
Difficulty swallowing / Hoarseness
Emphysema / Tuberculosis / COPD
Asthma / Pneumonia / Hay Fever
Chronic Sinusitis
Other: _____

Heart, Blood Vessels: ☐ YES ☐ NO
Chest pain / Angina
Heart attack / Congestive Heart Failure
Pacemaker / ICD / Artificial heart valve
Heart defects / Heart murmur / Heart surgery
History of Endocarditis / Valvular heart disease
High blood pressure / Low blood pressure
High cholesterol
Easily bleeding / bruising / Blood thinner medicine
History of blood transfusions
Sickle cell disease/trait
Anemia / Hemophilia
Other: _____

Digestive: ☐ YES ☐ NO
Hepatitis / Liver disease Type: _____
Ulcers / Gastric disease
Colitis / Crohn's / Celiac / Intestinal disease
Gastric Reflux / GERD / Vomiting
Other: _____

Nervous System: ☐ YES ☐ NO
Stroke / Cerebrovascular disease
Epilepsy / Seizures Last episode: _____
Frequent headaches / Migraines / Parkinson's
Head or neck trauma
Numbness / Tingling / Dizziness / Fainting
Dementia / Alzheimer's / Mental impairment
Other: _____

Bones, Muscles: ☐ YES ☐ NO
Arthritis / Rheumatism / Gout
Artificial joints/Limbs Location: _____
Osteoporosis / Bone density medicine
Fibromyalgia / RSD / Multiple Sclerosis
Other: _____

Endocrine: ☐ YES ☐ NO
Diabetes HbA1c or glucose: _____
Thyroid condition / Hormone imbalance
Other: _____

Genitourinary: ☐ YES ☐ NO
Kidney disease / Bladder disease
Dialysis Frequency: _____
Venereal disease / STD / HIV / AIDS
Frequent urination / Blood in urine
Other: _____

Female: ☐ YES ☐ NO ☐ N/A
Pregnant # of months ____due date_____
Breastfeeding

Other: ☐ YES ☐ NO
Fatigue / Daytime sleepiness
Sjorgren Syndrome / Autoimmune disorder
Phobias / Anxieties / Depression
Learning Disorders / ADHD / ADD
Developmental Disorders
Psychiatric treatment
Cancer / Radiation / Chemotherapy

Other Diseases / Conditions you think we should know about**:** _____

_____

ALLERGIES OR DRUG REACTIONS: ☐ YES ☐ NO _____

_____

*****PLEASE LIST ALL CURRENT MEDICATIONS ON BACK OF THIS FORM.**

I have answered every question accurately. I will inform my dentist of any change in my health and/or medication.

Patient Signature_____Date: _____

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Please list ALL your prescription drugs, over-the-counter drugs, vitamins, and herbal supplements:

	What I'm taking:	How Much, How often?	For What?
1			
2			
3			
4			
5			
6			
7			
8			
9			
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