New Patient Information Sheet

How did you hear about us? Friend □ Radio Ad □ Newspaper Ad □ Flyer □ Community Event □

Section 1: Patient Information

If the patient is under the age of 18, please complete **Section 3 of this form- **Responsible Party/Parent Information****

Patient Name: _____, _____ _____
Last Name First Name M.I.

Mailing Address: _____ **Physical Address** (if different): _____
PO Box or Street Street

City: _____ **State**: _____ **Zip Code**: _____ **County**: _____

Social Security Number: _____-_____-_____ **Birth Date**: ____ /____ /____ **Birth City and State: _____**
Month Day Year

Phone Number: (____) _____ **Cell Number**: (____) _____ **Driver's License #**: _____ **State**: ____

Email Address: _____

Employer: _____ **Employer Address**: _____
Employer Phone Number: (____) _____
Occupation: _____

What is your Gender Identity: Male_____ Female_____ Transgender_____ I choose not to disclose_____

What is your Sexual Orientation: Heterosexual_____ Homosexual_____ I choose not to disclose_____

Marital Status: Married Single Widowed Other: _____

Employment: Disabled Full-time Part-time Retired Self-employed Unemployed

Student: Fulltime Part-time N/A

Military: Active Retired Veteran None

Language: English Spanish Other (please specify) _____

Race: Black/African-American American Indian Asian Caucasian Hispanic Pacific Islander More than one race

Ethnicity: American Indian Asian African American Hispanic Native Hawaiian Pacific Islander Caucasian

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Emergency Contact: _____ _____ _____
First name **Last Name** **Phone Number**

Do you work in the fields or with produce: YES NO **Farmworker**: Migrant Seasonal Not Applicable

Do you live in a: Doubling up (two or more families) Shelter Transitional Housing Street/Vehicle Not Homeless
Public Housing: Family Tenant Section 8 Senior Housing Vicinity of Section 8 Not Applicable

Number of Children in household/family: _____ **Number of adults in household/family**: _____

Smoker: Yes_____ NO_____

Section 2: Insurance Information **(Please present a current copy of your insurance card(s) to the Front Desk)**

Are you the responsible party for Bill: yes ☐ no ☐ (If you are not the responsible party please complete Section 3)

Do you (the patient) have: Medical Insurance: yes ☐ no ☐ Dental Insurance: yes ☐ no ☐

If you answered yes to the above question, what type of insurance do you have (check all that apply**):**

Medicaid ☐ NC Health Choice ☐ Medicare ☐ Commercial/Private Insurance ☐ Dental Insurance ☐

Insurance Carrier Name: _____

Insurance Policy Number: _____ / Group Number: _____

Are you the primary insurance policy holder: yes ☐ no ☐

If you are not the policy holder, who is the primary insurance policy holder: _____

Your relationship to the Insurance Policy

holder: Spouse ☐ Child ☐ Other ☐ _____

Section 3: Responsible Party/Parent Information

Name: _____ Social Security #: _____-_____-_____

Is your address the same as the patients: yes ☐ no ☐

If no, what is your full mailing address: _____

Phone Number: _____ Driver's License # _____ State: _____

Date of Birth: _____ /_____ /_____ Gender: Male ☐ Female ☐ Marital Status: Married ☐ Single ☐ Other ☐

Occupation: _____

Employment: Full-time ☐ Part-time ☐ Retired ☐ Self-employed ☐ Un-employed ☐ Disabled ☐ Seasonal Worker ☐

AUTHORIZATION FOR TREATMENT

I, the undersigned hereby authorize PFMC and (PCP Name) _____ (and whomever he/she may designate and His/Her assistants) to administer such treatments as necessary. I also certify that no guarantee off assurance has been made to results of this treatment.

Signed: _____ Date: _____

Name (if signed by someone other than the patient): _____ Relationship: _____

Witness (Office Personnel): _____ Date: _____ Time: _____

You will be expected to pay any insurance co-pays at the time of visit and/or payment for services **NOT** covered by your insurance. If you feel you are unable to pay the full charge for your medical treatment, please inquire about our **SLIDING FEE APPLICATION.** If you do not qualify for sliding fee and are unable to pay at the time of treatment, please speak with billing before receiving treatment.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND BENEFIT ASSIGNMENT

PFMC is authorized to release any medical information required in processing of applications for financial coverage for services rendered and authorized to request payment for benefits directly to PFMC ON MY BEHALF.

Signed: _____ Date: _____

*This organization is required to maintain privacy and confidentiality for your health information and provide you with notice as to our legal duties and Privacy Practices with respect to information we collect and maintain about you.**

You must provide income verification in the form of check stub, W-2, or income statement from an employer. If you DO NOT wish to provide this information, you are declining the "sliding fee scale" and will be charged at 100% for your treatment.

_____ Yes, I will provide income verification within 7 days and annually, and if I fail to return the required documentation within the 7 days and annually, I agree to be charged at 100%.

_____ No, I have been offered the "sliding fee scale", but I decline to participate and I will pay at 100% for my treatment.

PERSON FAMILY MEDICAL AND DENTAL CENTER

The following information is requested by the Federal Government in order to monitor compliance with Federal Laws prohibiting discrimination against users of Person Family Medical and Dental Center. You are not required to furnish this information, but you are encouraged to do so. This information will not be used to discriminate against you in any way, nor will it be released except in aggregate form.

Income Category: Please place a check mark in appropriate box [] to indicate your annual household income.

	Number in Family	Annual Family Income
□	1	$ 0 - $10,890
□	1	$ 10,891 - $13,613
□	1	$ 13,614 - $16,335
□	1	More than $19,058
□	2	$0 - $14,710
□	2	$14,711 - $18,388
□	2	$18,389 - $22,065
□	2	More than $22,066
□	3	$0 - $18,530
□	3	$18,531 - $23,163
□	3	$23,164 - $27,795
□	3	More than $27,796
□	4	$0 - $22,350
□	4	$22,351 - $27,938
□	4	$27,939 - $33,525
□	4	More than $33,526
□	5	$0 - $26,170
□	5	$26,171 - $32,713
□	5	$32,714 - $39,255
□	5	More than $39,256
□	6	$0 - $29,990
□	6	$29,991 - $37,488
□	6	$37,489 - $44,985
□	6	More than $44,986
□	7	$0 - $33,810
□	7	$33,811 - $42,263
□	7	$42,264 - $50,715
□	7	More than $50,716
□	8	$0 - $37,630
□	8	$37,631 - $47,038
□	8	$47,039 - $56,445
□	8	More than $56,446

PERSON FAMILY MEDICAL AND DENTAL CENTER

P.O. Box 350
702 N. Main St.
Roxboro, NC 27573
Telephone: (336) 599-9271 Fax: (336) 599-0969

INFORMED CONSENT FORM FOR THE TESTING FOR ANTIBODIES TO HEPATITIS B AND HIV III

I, hereby, authorize Person Family Medical and Dental Center laboratory to perform a venipuncture and to obtain the necessary amount of blood needed to properly test my blood for antibodies to the Hepatitis B (HBV) and HIV (AIDS) virus, in the event a Person Family Medical and Dental Center's employee is punctured with an instrument and/or needle that has been contaminated with the undersigned patient's bodily fluids.

Results of this test will be forwarded to your physician. He/She will counsel you on what the results read and what the test means. A copy will be kept here in our office as well. Test results take approximately four to five
(4 to 5) business days to return. It will be your responsibility to return within in six (6) months for another blood test to finish all the testing needed.

_____ _____
(Name of Patient's Primary Care Provider) (Office Phone Number)

_____ _____
(Patient/Parent/Guardian) Printed Name (Date)

_____
(Patient/Parent/Guardian) Signature

_____ _____
Technician Printed Name Date

_____
Technician Signature

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Patients Name: _____ **Date of Birth:** _____
(please print)

I have been presented with a copy of Person Family Medical and Dental Center's Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law. I understand the contents of this Notice.

I understand I have the right to request restrictions concerning the use of my information. I request the following restrictions:

_____
_____
_____
_____

With whom may we discuss your treatment?

_____
_____
_____
_____

With whom may we discuss your payment?

_____
_____
_____
_____

Patient Signature: _____ Date: _____
If not signed by the patient, please indicate your relationship to the patient

Relationship to patient: _____ Witnessed By: _____

(Internal Use Only)

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to the patient and sign below.

Presented on (Date): _____ Time: _____
By: _____ Title: _____
(Name of Office Personnel)

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECETED HEALTH INFORMATION

With my consent Person Family Medical and Dental Center (PFMDC) may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to PFMDC's Notice of Privacy Practices for a complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. PFMDC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the attention of:

Person Family Medical and Dental Center – CEO
P.O. Box 350
Roxboro, NC 27573

With my consent, PFMDC my call my home or other designated location and leave a message on my voicemail/answering machine or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, collection action regarding delinquent accounts, and any call pertaining to my clinical care, including laboratory results among others.

With my consent, PFMDC may mail to my home or other designated location any items that assist in the practice of carrying out TPO, such as appointment reminder cards, patient statements, and miscellaneous correspondence.

With my consent, PFMDC may e-mail or facsimile transmit to my home or other designated location any items that assist in the practice of carrying out TPO, such as appointment reminder cards, patient statements, and miscellaneous correspondence. I have the right to request that PFMDC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to PFMDC the use of and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the Practice has already made disclosures in reliance upon my consent. If I do not sign this consent, Person Family Medical and Dental Center may decline to provide treatment to me.

_____ _____

Signature of Patient/Parent/Legal Guardian **Patient's Name- Please Print**

_____ _____

Print Name of Patient/Parent/Legal Guardian **Date**

PERSON FAMILY DENTAL CENTER
ROXBORO LOCATION: 702 N. MAIN ST. ROXBORO, NC 27573
TELEPHONE: (336) 599-9271 FAX: (336) 330-0247
YANCEYVILLE LOCATION: 1076 NC HWY 86 N. YANCEYVILLE, NC 27379
TELEPHONE: (336) 694-5462 FAX: (336) 694-5403

DENTAL APPOINTMENT AGREEMENT

It is important for patients to keep their dental appointments, because broken appointments result in lost time that could have been used to treat other patients. It is the responsibility of the patient to remember and keep their appointments. As a courtesy, we will try to remind patients of their appointments at least two (2) days in advance. Please make sure to maintain your correct contact information with us, as we can only remind you of your appointment if we have an active/current phone number.

RESCHEDULING APPOINTMENTS

The dental staff understand that sometimes situations arise that require rescheduling of your appointment. If you need to reschedule, please call the dental clinic as soon as you know that you will not be able to keep the appointment, at least 24 hours in advance of the appointment time. This will give us enough time to schedule another patient in your place.

BROKEN APPOINTMENTS

If you miss a scheduled appointment or cancel it at the last minute, a broken appointment will be recorded in your dental chart. If you are more than fifteen (15) minutes late for an appointment, a broken appointment will also be recorded in your dental chart, and you may have to be rescheduled if there is not enough time to complete your procedure. It is not fair to keep other patients waiting because someone showed up late.

In order to complete your dental treatment plan, scheduled appointments are necessary. Therefore, if you have two (2) broken appointments during a six (6) month period, management reserves the right to deny your privilege of being able to schedule an appointment. The inability to schedule an appointment will delay the completion of your treatment plan.

I understand the Dental Appointment Agreement and agree to follow the terms of the broken appointment policy.

_____ _____

Patient Name (please print) **Date**

_____

Patient/Parent/Legal Guardian Signature

Dental Walk-In

Emergency Checklist

Patient's Name: _____
Date of Birth: _____

- **What tooth/area is giving you trouble?**
  _____
  _____
- **Are you in pain? YES NO**
- **How long have you been in pain? _____**
- **Is the pain constant? YES NO**
- **What triggers the pain? _____**
- **Does the pain keep you from sleeping? YES NO**
- **Do you feel like you are swollen? YES NO**
- **Can you see any external swelling in the mirror? YES NO**

On a scale of 1-10 (10 being the worst) how would you rate the pain?

0 1 2 3 4 5 6 7 8 9 10

- **What have you taken to control the pain? _____**
- **Are you getting relief? YES NO SOME**

Do Not Write Below this Line

For Dentist Use Only

Observations: _____
_____
Assessment: _____
_____
Plan: _____
_____

Dentist: _____ **Date: _____**

DENTAL HISTORY

Date of your Last Dental Visit: _____

****Check the appropriate answer for each of the questions listed below****

Please answer the following questions	YES	NO
Do your gums bleed while brushing or flossing?		
Are your teeth sensitive to hot or cold liquids/foods?		
Are your teeth sensitive to sweet or sour liquids/foods?		
Do you feel pain to any of your teeth?		
Do you have any sores or lumps in or near your mouth?		
Have you had any head, neck, or jaw surgeries?		
Do you have frequent headaches		
Do you clench or grind your teeth?		
Do you bite your lips or cheeks frequently?		
Have you had any orthodontic work done?		
Have you ever had prolonged bleeding following extractions?		
Have you ever had instruction on the correct method of brushing your teeth?		
Have you ever had instructions on the care of your gums?		

Have you ever experienced any of the following?

□ Clicking in your jaw
□ Pain (joint, ear, side of face)
□ Difficulty in chewing
□ Difficulty in opening or closing mouth

Comments:

_____
_____
_____
_____
_____

Medical History For Dental

Patient Name: _____ Date of Birth: _____
Gender: □ Male □ Female Age: _____ Height: _____ Weight: _____
Choose all that apply: □ Caucasian/White □ African American/Black □ Hispanic/Latino
□ American Indian/Eskimo □ SE Asian □Other Asian □ Hawaiian/Pacific Islander
□ No Response/Choose not to answer
Name of Physician: _____ Phone: _____
Physician Address: _____
When was your last physical? _____
Are your immunizations current? _____
Are you under the care of a Physician? _____
If yes, for what reason? _____
_____
Are you presently taking any medications/drugs/pills? _____
If yes, please list current medications here: _____
_____
Are you allergic (or have any adverse reactions) to?
□ Penicillin □ Amoxicillin □ Codeine □ Local Anesthetic □Aspirin □ Other
□ Other Antibiotic: (Please explain) _____ □ None
Are you sensitive or allergic to latex? (i.e. Experienced itching, rash, or wheezing after using latex gloves or handling a balloon) □ YES □ NO If yes, please explain: _____
Have you had any unusual or unexplained reactions during a surgical procedure?
□ YES □ NO If yes, please explain: _____

****Do you have, or have you had any of the following: (Yes or No) Answer Y for Yes and N for No****

Abnormal Blood pressure _____	Epilepsy _____	Osteoporosis _____	Congenital Heart Disease _____
Alcohol Addiction _____	Fainting Spells _____	Prolonged Bleeding _____	Cortisone Medicine _____
Anemia _____	Glaucoma _____	Prosthetic Implants _____	Diabetes _____
Anorexia _____	Hearing Impaired _____	Psychiatric Care _____	Recreational Drugs _____
Arthritis/Rheumatism _____	Heart Disease/Surgery _____	Radiation Therapy _____	Emphysema _____
Artificial Heart Valve _____	Heart Murmur _____	Removal of Spleen _____	Liver Disease _____
Artificial Joint _____	Heart Pace Maker _____	Rheumatic Fever _____	Lung Disease _____
Asthma _____	Hemophilia _____	Rheumatic Heart Disease _____	Mitral Valve Prolapse _____
Bulimia _____	Hepatitis _____ □ A □ B □ C	Sickle Cell Disease _____	Neurological Disorders _____
Cancer _____	HIV Positive/AIDS _____	Sinus Trouble _____	Organ Transplant _____
Chemical Dependency _____	Kidney Problems _____	Stroke _____	Tuberculosis _____
Chemotherapy _____	Learning Disability _____	Thyroid Problems _____	Tumors _____
Ulcers _____	Venereal Disease _____		

Have you had any other serious illness, hospitalization, or accident? YES NO
If yes, please explain: _____
Do you currently smoke? YES NO - Do you use any of the following tobacco products: □ Cigarettes
□ Cigars □ Pipe □ Chewing Tobacco □ None
Have you used tobacco products in the past? YES / NO – If Yes, how long ago? _____
Do you drink alcoholic beverages? YES / NO – If Yes, how much? _____

****WOMEN ONLY (Please answer yes or no to the following questions)****
Are you pregnant? ___ Are you nursing? _____ Do you take Birth Control Medications? _____
Do you plan to become pregnant? _____ # of Pregnancies: _____ # of living children: _____