

Person Family Medical & Dental Center

New Patient Information Sheet

How did you hear about us? Friend | Radio | Flyer | Facebook/Google | Community Event | Other
(Please **circle**)

Name: _____, _____, _____ Birth Date: ____/____/____
Last Name First Name MI MM DD YYYY

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Social Security #: _____ - _____ - _____ Email: _____

Phone #: (____) _____ Cell #: (____) _____ Would like to receive text reminders

Employer: _____ Phone: (____) _____

Emergency Contact: _____ Phone: (____) _____

Please **circle** one from each of the following options:

Employment: Full-Time | Part-Time | Disabled | Retired | Self-Employed | Unemployed

Student: Full-Time | Part-Time | N/A

Military: Active | Retired | Veteran | N/A

Marital Status: Single | Married | Widowed | Other: _____

Language: English | Spanish | Other (please specify): _____

Gender Identity: Male | Female | Transgender | Choose not to disclose | Other: _____

Sexual Orientation: Heterosexual | Homosexual | Choose not to disclose | Other: _____

Ethnicity: Hispanic | Non-Hispanic | Unknown

Race: Black/African-American | White | Asian | Hispanic | Native American | Native |

Hawaiian | Choose not to disclose | Other: _____

Home: Not Homeless | Shelter | Street/Vehicle | Doubling up (2+ families) | Transitional

Public Housing: Section 8 | Senior Housing | Family Tenant | N/A |

Farm Worker: Migrant | Seasonal | N/A

Work with produce: Yes | No

Smoker: Yes | No

Person Family Medical & Dental Center

Insurance Information

(Please present a copy of your insurance card(s) to the front desk)

Do you (the patient) have:

Medical Insurance: Yes No | Dental Insurance: Yes No

Do you have the following: (circle all that apply)

Medicaid | Medicare | Commercial/Private Insurance | NC health Choice

Insurance Carrier Name: _____

Policy #: _____ Group #: _____

Are you the primary insurance policy holder? Yes No

If no, who is the policy holder? _____

Relationship to patient? _____ DOB: ____/____/____

Are you the responsible party? Yes No (If no, please complete the next section)

Responsible Party Information:

Name: _____ Birth Date: ____/____/____

Phone #: (____) _____ SSN: _____-____-____

Address (if different from patient): _____

City: _____ State: _____ Zip: _____

Consent for Treatment

I, the undersigned, hereby authorize PFMC and staff to administer such treatments as necessary. I also certify that no guarantee of assurance has been made to the result of this treatment.

Signed: _____ Date: ____/____/____

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 notices to our legal duties and Privacy Practices with respect to information we collect and maintain about you.

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 of your medical fee, please inquire about our SLIDING FEE APPLICATION. If you do not qualify and are unable to pay at the time of treatment, please speak with our billing department before receiving treatment.

Person Family Medical & Dental Center

*****Please place a check mark in the appropriate column***

<input checked="" type="checkbox"/>	Number in Family	Annual Family Income
	1	\$0 - \$10,890
	1	\$10,890 - \$13,613
	1	\$13,614 - \$16,335
	1	More than \$16,335
	2	\$0 - \$14,710
	2	\$14,711 - \$18,388
	2	\$18,389 - \$22,065
	2	More than \$22,065
	3	\$0 - \$18,530
	3	\$18,531 - \$23,163
	3	\$23,164 - \$27,796
	3	More than \$27,796
	4	\$0 - \$22,350
	4	\$22,351 - \$27,938
	4	\$27,939 - \$33,525
	4	More than \$33,525
	5	\$0 - \$26,170
	5	\$26,171 - \$32,713
	5	\$32,714 - \$39,256
	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

The following information is requested by the Federal Government in order to monitor compliance with the 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.

Number of adults in the household: _____

Number of children in the household: _____

Non-Insured Patients:

You must provide income verification in the form of check stub, W-2, or income statement. If you DO NOT wish to provide this information, you are declining the "Sliding Scale Fee" and will be charged 100% of your treatment fees.

Decline:

Person Family Medical & Dental Center

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

***** THIS IS ONLY IN THE EVENT THAT A PFMDC STAFF MEMBER IS
INJURED DURING YOUR TREATMENT *****

I, hereby, authorize Person Family Medical and Dental Center's 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** that a Person Family Medical and Dental Center employee is punctured with an instrument/needle that has been contaminated with my bodily fluids (undersigned patient).

Results of this test will be forwarded to your physician. He/She will counsel you on what the results mean. A copy will also be kept here in our office. Tests take approx. 4-5 business days to return. It will be your responsibility to return within 6 months for another blood test to finish all appropriate tests needed.

Patient's Primary Care Physician: _____

Office number: (_____) _____

(Patient/Parent/Guardian) PRINT

(Patient/Parent/Guardian) SIGN

Date: _____ / _____ / _____

Person Family Medical & Dental Center

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED 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 disclosure.

I have the right to review the Notice Of Privacy Practices prior to signing this consent form. PFMDC reserves the right to revise the 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 may 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, including but not limited to: appointment reminders, insurance items, collection action regarding delinquent accounts, any call pertaining to my clinical care, and laboratory results among others.

With my consent, PFMDC may mail, e-mail, or facsimile to my home or other designated location any items that assist in the practice of carrying out TPO such as 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 for, 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, PFMDC may decline to provide treatment to me.

(Patient/Parent/Guardian) PRINT

(Patient/Parent/Guardian) SIGN

Date: ____/____/____

Person Family Medical & Dental Center

Patient-Provider Agreement

We are honored that you have chosen us to provide your dental care. We value our relationship with you and strive to always provide clear communication about our expectations.

Our Efforts: We make every effort to see you at your scheduled appointment time. Due to circumstances beyond our control, such as emergency patients, and procedures running long, we will sometimes run behind. Please allow enough time in your schedule for unseen delays. We apologize in advance for this possibility and want you to know that when it is your time, we will make the time we need to make things right.

Late Cancellations and No-Shows: We ask that you please call us as soon as you realize you will miss your appointment. We understand that things sometimes happen at the last minute that cause you to have to miss your appointment, and sometimes you may not be able to call 24 hours ahead of time to let us know. Therefore, as a courtesy we will allow you to have: **3 late cancellations or no-call/no-show appointments in a 6 month period.** If you exceed this allowance, we will not be able to schedule you any appointments for 90 days. You may be seen only for emergencies during that time.

Late Appointments: We make every effort to see you at your scheduled appointment time. We understand sometimes you will run late and will allow a **5-minute grace period** if you are late to your appointment. If you are **6-14 minutes late**, you may or may not have to reschedule, depending on what procedure was planned to be done and how the schedule is running that day. If you are **15 or more minutes late**, you will be rescheduled, except in rare cases when the schedule allows for us to stay on time.

Respect and Dismissal: We always strive to treat you with respect and we ask that you do the same for us. We strive to resolve any conflicts that arise in a calm and respectful manner. For the safety of our staff and patients, we will not tolerate intimidation, profanity, verbal abuse, or aggressive behavior. These behaviors may be grounds for suspension or dismissal, meaning that the person will no longer be a patients of Person Family Dental Center temporarily or permanently. We hope it never comes to this.

Concerns: You are always welcome to discuss any concerns you may have with our on staff dentist. If the dentist is not available at the time, you may leave your information for them to call you back.

*****I have read and understand this patient-provider agreement and I agree adhere to the policy therein.**

(Patient/Parent/Guardian) PRINT

(Patient/Parent/Guardian) SIGN

Date: _____/_____/_____

Person Family Medical & Dental Center

Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name: _____ Date of Birth: ____/____/____

I understand how my health information may be used and disclosed, and that above named practice will protect the privacy of my confidential health information under the laws of HIPPA. At any time, I have the right to request a full and updated/revised copy of the above named practices "Notice of Privacy Practices."

**I have requested/received a copy of the "Notice of Privacy Practices" for the above named practice.

Authorization for Release of Information:

I would like the below named individual(s) to be able to access my health and financial information on my behalf. You may discuss my treatment needs with the following:

Name: _____ Phone: (____) _____

Name: _____ Phone: (____) _____

I would ***NOT*** like to grant access to my financial/health information to anyone other than MYSELF

**I have the right to revoke this authorization at any time by contacting PFMDCC with the knowledge that the revocation request is not effective for previously released information.

_____ Date: ____/____/____

(Patient/Parent/Guardian) SIGN