Person Family Medical & Dental Center

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*

✓	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: _____/_____/_____

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Communications between Patients and their Families, Friends, or Caregivers

This form allows Person Family Medical Center (Name of Practice) to communicate information about your care (e.g., appointments, labs, medication, treatment plans, billing information) to you and those you list on this form. Signing this form is optional, is not required to receive treatment, and does not expire until you end it in writing.

Patient Name: _____
(Last) (First) (Middle Initial)

Date of Birth: _____ (mm/dd/yyyy) **Main Contact Number:** (___) _____
☐ Home ☐ Cell* ☐ Work

Mailing Address: _____
(Street)

_____
(City) (State) (Zip)

COMMUNICATING WITH YOU

PHONE

☐ Main Contact Number Above

☐ Other: (___) _____
☐ Home ☐ Cell* ☐ Work

DETAILED MESSAGES PERMITTED

☐ text (SMS)* ☐ voicemail/answering machine ☐ None

☐ text (SMS)* ☐ voicemail/answering machine ☐ None

EMAIL*

☐ _____

☐ All information from this practice
☐ Appointment information only (request/confirm/cancel)
☐ Data breach notifications
☐ Billing/insurance information

COMMUNICATING WITH YOUR FAMILY, FRIENDS, OR CAREGIVERS

☐ This practice may communicate to the family members, friends, or caregivers listed below.

Spouse/Partner: _____ (First and Last Name)
Phone: (___) _____
Email:* _____

Other: _____ (First and Last Name)
Phone: (___) _____
Email:* _____
Relationship: _____

Check the box next to each type of information this practice may share.

☐ All information ☐ Prescriptions ☐ Appointments (request/confirm/cancel) ☐ Billing/Insurance
☐ Other: _____

Do not include:

☐ Mental health records ☐ Communicable diseases (e.g., HIV/AIDS) ☐ Alcohol/drug abuse treatment

* I understand that emails and texts are not always secure ways to communicate and could be intercepted and read by a third party. I am willing to accept this risk.
This practice is not responsible for the privacy or security of your health information once it is sent to you, or the recipient(s) listed above.

YOUR PHOTOS & MULTIMEDIA

	Photos/Images may be used/posted:
☐ Photo received from you or personal representative	☐ In office
☐ Photo taken by staff (e.g., pre/post procedure)	☐ On office's website
☐ Other:_____	☐ Other: _____

PATIENT RIGHTS & SIGNATURE

- You can end this authorization at any time in writing. See our Notice of Privacy Practices for exceptions. A termination will not apply to any releases of information that happen before we receive a written termination from you.
- The recipient of the information could use or release it in a way that federal or state laws do not protect. This practice is not responsible for the privacy or security of your health information after it is sent to those listed on this authorization.
- You can review or copy the information that will be used or released as described in this authorization.
- You do not have to sign this authorization to receive treatment from this practice.
- You understand that the information that will be used or released might include a communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse unless you exclude it above.
- All changes or updates to this form must be made in writing and signed by you (patient) or your personal representative. Minor edits (e.g., new phone number) can be made on this form, initialed, and dated instead of requiring a new form.

_____ _____

Patient/Personal Representative Signature **Date:** **mm/dd/yyyy**

Printed name and description of Personal Representative's authority (e.g., healthcare power of attorney)
(Attach documentation to support the personal representative's authority if not already on file with the practice)

_____

FOR OFFICE USE & REFERENCE ONLY

☐ This authorization has been terminated: _____
mm/dd/yyyy

The termination must be in writing and filed with the original authorization.

Date original signed authorization received: _____
mm/dd/yyyy

☐ Copy of original authorization provided to patient/personal representative (check if yes)

Notes: _____

_____

_____

It is recommended that the practice review this form with the patient or their personal representative periodically for changes (e.g., annually with insurance verification).

PERSON FAMILY MEDICAL AND DENTAL

HEALTH HISTORY

Date: _____

Patient Name: _____ **DOB:** _____

Name of Primary Care Dr: _____ **Phone:** _____

When was your last physical? _____ **Are your immunizations up to date?** _____

Are you currently under the care of another physician besides your primary care Dr? _____

Why? _____

Who is your preferred pharmacy? _____

Please list any **MEDICATIONS** and supplements you are taking: _____

_____

Please list any **ALLERGIES** as well as your reaction to them: _____

_____

Please list all past **SURGERIES**: _____

_____

Have you ever had any unusual or unexplained reactions during a surgical procedure? _____

_____

Have you had any other serious illness, hospitalization or accident? If yes, explain: _____

_____

Are you pregnant? _____ Are you nursing? _____ Do you take birth control medications? _____

Do you anticipate becoming pregnant? _____

Do you currently smoke or use tobacco products? _____ Have you ever used them in the past? _____

Do you drink alcoholic beverages? _____ If yes, how much? _____

Date of last dental visit? _____

Do you have, or have you had any of the following? (*Mark only those that apply to you*)

- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Heart Defect
- ☐ Heart Disease
- ☐ Heart Surgery
- ☐ Artificial Heart Valve
- ☐ Pacemaker/Defibrillator
- ☐ Taking blood thinner

- ☐ Neurological problems
- ☐ Stroke
- ☐ Epilepsy/seizures
- ☐ Multiple Sclerosis
- ☐ Fainting spells
- ☐ Hearing impairment
- ☐ Visual impairment
- ☐ Memory problems

- ☐ Asthma
- ☐ Emphysema
- ☐ COPD
- ☐ Obstructive Sleep Apnea
- ☐ Seasonal Allergies
- ☐ Sinus problems

- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Thyroid Problems
- ☐ Arthritis
- ☐ Artificial joint

- ☐ Anemia
- ☐ Hemophilia
- ☐ Sickle Cell Disease
- ☐ Prolonged Bleeding
- ☐ Cancer
- ☐ Chemotherapy/Radiation

- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Irritable Bowel Syndrome
- ☐ Acid Reflux (GERD)
- ☐ Stomach ulcers
- ☐ Hepatitis A__ B__ C__

- ☐ Eating disorder
- ☐ ADHD
- ☐ Depression
- ☐ Anxiety
- ☐ Schizophrenia
- ☐ Bipolar
- ☐ Mood disorder
- ☐ Substance use disorder

- ☐ Autoimmune disease
- ☐ Organ transplant
- ☐ Removal of spleen

Do you have any other medical issues that you have that have not been addressed above?

_____

_____

_____