Dental Clinic
New Patient Packet

INSTRUCTIONS FOR "NEW PATIENTS"

MUST PROVIDE MEDICAL/DENTAL INSURANCE INFORMATION IF AVAILABLE.

THE FOLLOWING/ATTACHED FORMS MUST BE FILLED OUT and RETURNED BEFORE YOU CAN SCHEDULE YOUR APPOINTMENT:

- Dental Clinic - No-Show Policy
  Sign and Date

- Informed Consent
  Fill out ALL information

- Medical History - Dental
  Fill out ALL information

- Dental – Medication/Drug List
  Fill out ALL Information

08/2016
ERIE COUNTY COMMUNITY HEALTH CENTER
DENTAL CLINIC
420 Superior Street * Sandusky, Ohio  44870

NO SHOW POLICY
Effective August 1, 2014

* Established patients who “No-Show” for their scheduled appointment 2 times within a
one-year period will be terminated from our practice until they attend a no-show class.

* New patients who “No-Show” for his/her first appointment will not be scheduled for an
appointment until they attend a “No-Show” class.

* You may call 24 hours a day to cancel your appointment. If you call to cancel an
appointment after office hours, leave a message with Dental Triage at 419-626-5623,
Ext. 218.

* Dental appointments must be cancelled 24 hours in advance. Cancellations made less
than 24 hours will be considered a “No-Show” and must follow the “No-Show” policy.

* First time “No-Show” terminated patients must attend a “No-Show” class. The “No-Show”
classes are typically offered every other month. There are morning and evening classes
available. After attending a “No-Show” class, the patient is allowed back into the practice
and may schedule an appointment.

* Further terminations for “No-Show” require a one-year termination period. The patient may
be scheduled to meet the Dental Director or designee to discuss this matter. If approved,
and after signing a re-admittance agreement, the scheduling restriction will be removed.

* Appointments will be removed for patients with non-working telephones, voice mailbox is
full or not set-up. Per voice mail message, the patient must call the dental clinic no later
than noon of the following day to confirm their intention to keep the appointment.
Appointments will be removed for patients who do not call back to confirm. Patients
whose appointments have been removed, but who show up for their appointments, will
be offered the opportunity to sit and wait to be worked in or rescheduled for another day.

* Patients who do not arrive for an appointment, cancel with less than 24 hours’ notice or
show up more than 10 minutes late will be documented as having missed their
appointment/no-show.

* Patients who miss a second appointment within the same calendar year, cancel with less
than 24 hours’ notice or show up more than 10 minutes late will be documented. All
future appointments for these patients will be cancelled.

__________________________________________  _________________________________
Signature                                           Date
ERIE COUNTY COMMUNITY HEALTH CENTER
420 Superior Street – Sandusky, Ohio 44870 419-626-5623 / Fax 419-626-4824

INFORMED CONSENT

Client Name ___________________________________________ Date of Birth ________

I give my consent for the Erie County Community Health Center (ECCHC) to provide treatment. _______ (initial)

RELEASE/SHARING OF INFORMATION
I authorize the ECCHC to release and obtain verbal, written and electronic health information about the above-named client to and from health care providers involved in the medical and/or dental treatment and management of the client’s medical or dental care and with specialists we may refer to. This release may include all health care including behavioral, mental health and addiction care pertinent to my medical/dental treatment at ECCHC. _______ (initial)

I authorize release of all health information except: ____________________________________________________________

I understand that these records are protected under federal and state laws and regulations and cannot be disclosed without my written consent unless otherwise provided by law.

I authorize the ECCHC to release any information from the client’s medical/dental records to medical assistance, Medicare, other governmental payers, private insurance companies or plans or organizations acting on their behalf, as may be necessary to determine benefits and process claims and others involved in the collection of accounts.

PAYMENT OF SERVICES
I authorize (name of insurance company) ________________________________ to assign the amount payable under the client’s contract directly to the ECCHC. I understand that I am financially responsible for all charges that are not covered by private insurance company. I also understand that I am responsible for knowing the benefits covered under the client’s private insurance plan.

I understand that I am responsible for notifying the ECCHC if there is a change in the insurance coverage, my address and my telephone number.

I acknowledge that co-payments or nominal fees are due and payable on the date services are received.

I, __________________, state that there are _____ people living in my household and household annual income is ______________. If declaring no income, I agree to complete and sign the IRS 4506-T form. _______ (initial)

I agree, whether as a patient, agent, guardian, relative, or representative, that in consideration of the services rendered, I hereby individually guarantee and obligate myself to pay the account of the ECCHC in full. I further understand that failure to comply with my responsibilities for payment of services rendered may result in suspension of appointments.

SLIDING FEE SCALE AGREEMENT: I understand and agree that some services rendered are based on my ability to pay. Title X Family Planning clients will not be denied family planning services due to inability to pay. If payment for other services is determined by and based on a sliding fee scale, I understand that I am responsible for my share of the cost of services rendered and that failure to provide “proof of income” will result in being charged 100% of the cost of services received or provided.

RECEIPT OF NOTICES
I have been given a copy of or have read ECCHC’s Notice of Privacy Practices, Patients’ Bill of Rights and Patient Responsibilities. _______ (initial)
I have read and understand the ECCHC “No-Show/Cancellation” policy and agree to abide by the guidelines as stated in the policy. ______ (initial)

**VACCINES**

In regards to vaccines, I grant my permission for this record to be released to medical providers, health departments, schools and day care centers. I have received a copy, have read or had read to me the information on the appropriate VIS sheet about the vaccine(s) and my questions were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and ask that the vaccine(s) be administered to me or the person named for who I am authorized to make this request. ______ (initial)

Does the health insurance cover vaccines? **YES** **NO**

**NOTIFICATION/CONTACT**

At times ECCHC will need to notify patients for various reasons. ECCHC will call the patient 2-3 days before an appointment to remind the patient of their upcoming appointment. If ECCHC needs to contact the patient or return a patient’s phone call for additional reasons, ECCHC can: (please initial your contact preference)

_____ Call my telephone number, but do not leave a message if I do not answer.

_____ Call my telephone number and identify ourselves as ECCHC to the person answering or in a voicemail.

_____ Call my telephone number and leave a detailed voicemail as to why we are calling.

Please list an emergency contact (if a minor, please provide someone who will not be bringing the minor).

Name/Relationship ______________________ Telephone Number ______________________

If ECCHC is not able to reach you by telephone, would you like us to contact your emergency contact?

_____ NO, Emergency contact will only be used as a contact in an emergency. (Initial)

_____ YES: (please initial your contact preferences for emergency contact).

- _____ ECCHC may call my emergency contact listed and notify them to contact me to call ECCHC and provide no further details.
- _____ ECCHC may call my emergency contact listed and provide information either over the phone or in voicemail as to why we are calling.

In the event of an abnormal test results and the inability to contact me by all other means, I authorize ECCHC to contact me in writing at the current address provided by me.

**Parental Consent of Minor Children:** The following individuals are permitted to bring my child for treatment services:

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<th>Name</th>
<th>Relationship</th>
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MINORS MUST BE ACCOMPANIED BY PARENT, LEGAL GUARDIAN OR INDIVIDUAL NAMED IN PARENTAL CONSENT LISTED ABOVE.

I give my consent for ECCHC to provide medical/dental care to the adolescent (age 16 & 17) listed above in the event that I am not present for the appointment ______ (Parent or Guardian Initial)

I am a minor seeking confidential Sexually Transmitted Infection or Family Planning Services  □ No  □ Yes ____ (initial)

This consent is in effect until January 1st following the date of signature.

Signature of Client / Parent or Guardian if a Minor ______________ Date _______________ Witness ______________________

(G:Primary Care/Forms/Informed Consent 9.2015)
MEDICAL HISTORY - DENTAL

Patient Name: ___________________________ Date: ________________
          Last       First       MI

Address: _______________________________________________________________
          Number and Street          City          State          Zip

Home Phone: ___________________________ Work Phone: ______________________

Date of Birth: ________________ Sex: M  F  Height: ___________ Weight: ________

If you are completing this form for another person, what is your relationship to that person?
___________________________________________________________________________

Patient’s Family Doctor: ___________________________

Approximate Date of Last Medical Visit: __________ Approximate Date of Last Dental Visit: __________

PLEASE ANSWER EACH QUESTION

CIRCLE

1. Are you in pain/swelling or have you been in pain/swelling in the past week? Yes No
2. Have you been under the care of a physician during the past 2 years? Yes No
3. Are you allergic to penicillin or any drugs or medicine? Yes No
   Please list: ____________________________________________

4. Have you ever had any excessive bleeding requiring special treatment? Yes No

5. Circle any of the following which you have or have had:
   Heart Disease  Tuberculosis (TB)  Anemia  Epilepsy  HIV
   Cancer, Tumor  Rheumatic/Scarlet Fever  Arthritis  Asthma  Sinus Trouble
   Cardiac Pacemaker  Psychiatric Treatment  Hepatitis  Heart Murmur  Jaundice
   Cancer Treatment  High Blood Pressure  Cough  Diabetes  Stroke
   Surgery/Artificial Joints  Sexually Transmitted Disease - Type: __________

6. Have you had any other medical conditions of which we should be aware? Yes No
   Please list: ____________________________________________

7. (Women) Are you pregnant now? Yes No
8. (Women) Are you currently nursing? Yes No
9. Have you ever been diagnosed or treated for chemical dependency or alcoholism? Yes No
   If YES, when was your last usage and what was it? __________________________

10. Have you taken any kind of medicine or drugs during the past year? Yes No

Please list all medications you are currently taking on the medication sheet.

Signature: ___________________________________________ Date ________
           (Patient, Parent or Guardian)

07/22/13; Rev. 07/31/14
DENTAL
MEDICATION/DRUG LIST

Today's Date ________________

Name ________________________  Date of Birth ____________________

Medications your dentist uses in routine dental treatment may interact with both prescription and non-prescription drugs including herbal supplements.

These reactions may result in SEVERE INTERACTIONS. It is extremely important that you inform your dentist of any drug you currently use or may have taken so that this may be considered in your dental treatment planning.

This information will be held in strict confidence and will be used only for safe, appropriate dental care.

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