CHRIST COMMUNITY HEALTH

For Office Use
Entered by: _____
Date: _____

New Dental Patient Packet

Patient Information

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

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____
May we leave a voicemail? ❒ Yes ❒ No *May we leave a voicemail?* ❒ Yes ❒ No *May we leave a voicemail?* ❒ Yes ❒ No

Date of Birth: _____ Gender: ❒ Male ❒ Female Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Separated ❒ Widowed

Patient SSN: _____ Email Address: _____

Employment: ❒ Full-time ❒ Part-time ❒ Student ❒ Retired ❒ Active Military ❒ Unemployed Number of people in your household: _____

How often are you paid? ❒ Weekly ❒ Biweekly ❒ Monthly ❒ Annually Gross income *(before taxes)* during the period: $ _____

Patient Race: ❒ American Indian/Alaska Native ❒ Asian ❒ Native Hawaiian ❒ Black/African American ❒ White ❒ Other Pacific Islander

Patient Ethnicity: ❒ Hispanic/Latino ❒ Not Hispanic/Latino Patient Primary Language: ❒ English ❒ Spanish ❒ Other _____
Do you require translation? ❒ yes ❒ no

Are you a Veteran? ❒ yes ❒ no
Are you an Agricultural Worker? ❒ yes ❒ no
Are you Homeless? ❒ yes ❒ no If yes, what is your status? ❒ Street ❒ Doubling up ❒ Transitional Housing ❒ Shelter ❒ Other
Are you a Public Housing Resident? ❒ yes ❒ no

Emergency Contact
Relation to Patient: _____
Name: _____
Address: _____
Phone: _____
May we leave a voicemail on this phone? ❒ Yes ❒ No

Primary Pharmacy
Name: _____
Address: _____
Phone: _____
Fax: _____

Reason for Seeking Care: _____
Please list any medical conditions or information that could help us provide better care to you:
_____

Insurance Information *(Please present insurance card to front desk)*

Primary Insurance
Carrier Name: _____
Policy Holder ID: _____
Group #: _____ Copay ($): _____

Subscriber Name: _____
Relation to Subscriber: _____
DOB: _____ Gender: ❒ Male ❒ Female
❒ I have other family that goes here ❒ I am a patient here too

Secondary Insurance
Carrier Name: _____
Policy Holder ID: _____
Group #: _____ Copay ($): _____

Subscriber Name: _____
Relation to Subscriber: _____
DOB: _____ Gender: ❒ Male ❒ Female
❒ I have other family that goes here ❒ I am a patient here too

Responsible Party *(please complete if other than the patient)*

The patient is my: ❒ Self ❒ Spouse ❒ Child ❒ Grandchild ❒ Other
Name: _____ Address: _____
Phone: _____ DOB: _____ Gender: ❒ Male ❒ Female
May we leave a voicemail on this phone? ❒ yes ❒ no

_____ _____
Patient or Guardian Signature **Date**

CHRIST COMMUNITY HEALTH

Privacy Policy Acknowledgement (Health Insurance Portability and Accountability Act: HIPAA)

Patient Name (Last)	(First)	(Middle Initial)	Date of Birth

I have had the opportunity to review the Notice of Privacy Practices for PHI (Protected Health Information) before signing this consent. I give permission to Christ Community Health Services Augusta (CCHSA) to disclose information about myself (or another person for whom I have the authority to sign) for the purposes of treatment, payment, and healthcare operations. I also authorize Christ Community Health Services Augusta to communicate with the following individuals about my condition or treatment. I understand that I have the right to restrict how the Practice discloses my PHI, and that I can revoke this authorization at any time.

May we leave a voicemail or text *(if applicable)* **on your:**
Home Phone? ❒ Yes ❒ No
Cell Phone? ❒ Yes ❒ No
Work Phone? ❒ Yes ❒ No

I give permission to CCHSA to communicate with the following individuals regarding my condition or course of treatment:

Emergency Contact Name	Relationship to Patient	Phone Number	May we leave a voicemail? ❒ Yes ❒ No
Guardian Completing Form *(if applicable)*	Relationship to Patient	Phone Number	May we leave a voicemail? ❒ Yes ❒ No
Name	Relationship to Patient	Phone Number	May we leave a voicemail? ❒ Yes ❒ No
Name	Relationship to Patient	Phone Number	May we leave a voicemail? ❒ Yes ❒ No

Patient or Guardian Signature **Date**

Authorization, Assignment, Financial, No-Show, and Pain Management Policy

1) I do hereby voluntarily consent to medical/dental care at Christ Community Health Services, Augusta (CCHSA). I hereby authorize all Dentists and their assistants including Dental Assistants and Yg employed by CCHSA to use such diagnostic and treatment procedures they deem necessary for proper medical management and treatment. I understand that Physician Assistants and Nurse Practitioners are not licensed physicians and may help provide medical care only under the supervision and direction of a licensed physician.
2) I also assign the claim payments to be made payable to CCHSA.
3) I agree to the release of information to Medicare, Medicaid, and third party payers. I understand that some of the services that may be ordered may not be covered under Medicare, Medicaid, and other insurance and I am responsible for any amounts not paid.
4) I understand that payment in full is expected before services are rendered. I understand that insured patients must pay their copay, and uninsured patients must pay their sliding fee charge.
5) I understand that patients must provide proof of income in order to qualify for sliding fee scale.
6) I understand that if I am a new patient, and I do not come to my first appointment, I may only reschedule one time. If I do not come to this second new patient appointment, I will not be able to schedule another appointment for a year.
7) After coming to my first appointment, I am then considered an established patient. I understand as an established patient, that if I No-Show more than two appointments in a 12-month period, I may be terminated from this practice. I understand that it is my responsibility to call to cancel or reschedule the day before my appointment by 3pm, and that not doing so will result in a No-Show. Showing up without payment in full or more than 15 minutes late will also result in a No-Show. It is my responsibility to call to cancel or reschedule the day before my appointment if payment in full cannot be provided.
8) I understand that CCHSA will not fill narcotic prescriptions on a first appointment, nor do they guarantee that they will continue a current narcotic prescription.

Patient or Guardian Signature **Date**

CHRIST COMMUNITY HEALTH

127 Telfair St • 1226 D'Antignac St • Augusta, GA 30901 • 706-922-0600

Please fill out this form to ensure you are receiving all of the discounts we offer. We want to provide you with the most affordable primary care no matter your income or insurance status.

❒ *By checking the box, I decline to disclose my income and decline all possible sliding fee discounts.*

Sliding Fee Scale Application

First Name | Middle Initial | Last Name | Social Security No.

Present Address | Street | City | State | Zip

Telephone Number | Mobile Phone | Email Address

Household Members and Income: Please List all household members including ***yourself*** below. List additional family members on the back of this form.

Household Members			Paycheck	Unemployment	Social Security/ Disability	Food Stamps	Alimony/Child Support	Assistance from friends	Other	Total Monthly Income
Full Name	**Relation to you**	**Date of Birth**								
Ex. John F. Doe	***Self***	***1-1-10***	*$ 450*	*$ 0*	*$ 0*	*$ 200*	*$ 0*	*$ 100*	*$ 0*	*$ 750*

Total in Household: _____ **Total Monthly Household Income:** _____

Attention

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform Christ Community Health Services Augusta, Inc. if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of Christ Community Health Services Augusta, Inc. I hereby acknowledge that I read the foregoing disclosure and understand it.

_____ _____

Signature Date

Please provide one of the following from part A and

A. Proof of Identification

1. Driver's License
2. Valid Government ID
3. Current Utility Bill
4. SSN or Birth Certificate

B. Proof of Income (If not applicable, go to Section C)

1. Recent Federal Income Tax Return
2. Recent Stub for one month

C. Proof of *NO* Income

1. Notarized statement from person(s) who provide your financial support.
2. Statement from Social Security stating that you do or do not receive benefits
3. Statement from the department of Family and Children Services stating you do or do not receive benefits
4. Letter from public facility verifying residency and/or income

CHRIST COMMUNITY HEALTH

General Dental Consent Form

1. **Exam, X-Rays, and Cleaning:**
I understand that the initial visit will require radiographs in order to complete the examination, diagnosis, and treatment plan. If I do not have any periodontal concerns, a preventive ("regular") cleaning will be performed. If the dentist can not adequately perform my initial examination due to excessive calculus (tartar), or I am diagnosed with Periodontal disease, I understand that treatment will not initially be a preventive ("regular") cleaning. I understand that treatment may involve multiple visits in a short period of time to properly treat my condition. I will be given a "best" estimate of fees to properly treat my condition before treatment is performed.

2. **Drugs, medications, and sedation:**
I have been informed and understand that antibiotics, analgesics, and other medications can cause redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand and agree to not operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of prescribed analgesic or sedative medications. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

3. **Changes in Treatment Plan:**
I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on teeth that were not discovered during the examination, the most common being root canal therapy following routine restorative procedures, or the need for a pulp cap during the restorative procedure. I give permission to the Dentist to make any or all changes and additions as necessary.

4. **Temporomandibular Joint Dysfunction (TMD):**
I understand that symptoms of popping, clicking, locking, and pain can intensify or develop in the joint subsequent to routine dental treatment wherein the mouth is held in the open position for an extended period of time. However, symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, and the cost of which is the responsibility of the patient.

5. **Fillings:**
I understand that care must be exercised in chewing on filling material during the first 24 hours to avoid breakage, and tooth sensitivity is common after a newly placed restoration.

6. **Removal of Teeth (Extractions):**
If an extraction is needed, a separate consent form will be given explaining any possible complications. I will be informed of my options for replacing any missing teeth (implants, bridges, or removable prosthesis).

7. Periodontal Treatment:

I understand that if diagnosed with Periodontal disease, I have a serious condition causing gum inflammation and/or bone loss and that it can lead to loss of my teeth. I also understand that success of treatment depends, in part, on my efforts to brush and floss daily, receive maintenance cleanings as directed, follow a healthy diet, avoid tobacco products, and follow other recommendations. A separate consent form will be given for Periodontal Treatment further detailing the purpose of therapy and treatment that will be provided.

Consent:

I understand that dentistry is not an exact science, therefore: reputable clinicians can not properly guarantee results. Results rely heavily on my active role in maintaining proper oral health. I acknowledge that no guarantee or assurance has been made by anyone regarding dental treatment which I request and authorize. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist, other than the treating Dentist, is responsible for my dental treatment. **I may refuse any treatment that is proposed, but must inform the Dentist prior to work being performed.**

Patient/Guardian Signature:_____ Date:_____

Patient/Guardian Print:_____

CHRIST COMMUNITY HEALTH

No-Show Policy

No-Show Policy for Dental Department

Your dental providers want to make sure that you and other area residents have access to high-quality dental care when you need it. To ensure maximum access to dental services for all of our patients, please be aware of the following Appointment/No-Show Policy:

Scheduled Appointments: Although we will make every effort to remind you of your upcoming dental appointment by phone or by mail, **you are ultimately responsible for remembering your appointment date and time.** You should make the best effort to arrive 15-25 minutes before appointment time. If you arrive *more than* 15 minutes late to your appointment, it will be considered a "No-Show."

Canceling/Rescheduling Appointments: If you cannot make your scheduled appointment, you must call us at least 24 hours in advance to let us know, so that we can offer your appointment to another patient. Failure to provide at least 24 hours' notice counts as a "No-Show."

Missed Appointments (2-Strike Policy): **Because of the critical lack of access to dental services in our area, missed appointments (No-Shows) are taken very seriously.**

- New Patients: If you miss one appointment without proper notice you will lose scheduling privileges and be placed on the "Same-Day Appointment" list until appointments can be consistently maintained. Pediatric patients will be granted an exception.
- Established Patients: If you miss one appointment without proper notice it will be considered a "No-Show."
- Established Patients: If you miss a second appointment without proper notice within the same calendar year, you will lose scheduling privileges, and be limited strictly to "Same-Day Appointments." If patient consistently maintains "Same-Day Appointments," then restrictions will be lifted to allow access to the dental schedule.
    - Further actions will be taken at the discretion of the Dental Director for chronic No-Show patients.

Please talk to any of the dental staff if you have questions about our No-Show Policy.

I understand and agree to abide by this No-Show Policy.

_____ _____

Patient Signature Date

_____

Parent/Guardian Signature (for patients under 18)

Date Drafted	01/27/17
Date Revised	
Date Approved	