Patient Information

CHRIST COMMUNITY DENTAL

Patient Name	Last	First	Middle Initial	Date of Birth

Home Address	House #	Street	Apt #	City	State	Zip

Mailing Address	House #	Street	Apt #	City	State	Zip

☐ Check this box and leave mailing address blank if it is the same as your home address

Email Address	May we contact you via email? (circle one)	Yes | No

Home Phone	May we leave a voicemail? (circle one)	Yes | No
( ) -		

Cell Phone	May we leave a voicemail? (circle one)	Yes | No
( ) -	May we send a text message? (circle one)	Yes | No

Work Phone	May we leave a voicemail? (circle one)	Yes | No
( ) -		

Gender: Female | Male	**Social Security #:** - -

Pharmacy Name:

Insurance Information (Please copy this information from your insurance card)

☐ Check this box if the patient does not have any health insurance.

Primary Insurance

Carrier (Company)	**Group ID**	**Office Visit Copay** $

Subscriber Name	**Subscriber Date of Birth**

Policy Holder ID (for the patient)	**Subscriber's Relation to Patient** (circle one) Self | Spouse | Partner | Child | Other _____

Secondary Insurance

Carrier (Company)	**Group ID**	**Office Visit Copay** $

Subscriber Name	**Subscriber Date of Birth**

Policy Holder ID (for the patient)	**Subscriber's Relation to Patient** (circle one) Self | Spouse | Partner | Child | Other _____

Patient Information (page 2)

Responsible Party

☐ I am the patient. (You may skip this section; go to additional Information)

If you are the parent/legal guardian or are otherwise responsible for authorizing care and paying bills for the patient named above, please provide your name and contact information below.

The patient is my (circle one): Spouse | Partner | Child | Other _____

Name	Last	First	Date of Birth	SSN

Mailing Address	House #	Street	Apt #	City	State	Zip

Email Address

Additional PATIENT Information

Please circle one option for each question below. We are required to ask these questions, but you may skip any you are not comfortable answering.

Marital Status? Single | Married | Partner | Widowed | Divorced | Legally Separated

Employment Status? Full-time | Part-time | Not Employed | Self-Employed | Retired | Active Military | Student

Race? American Indian/Alaska, Native | Black or African American | White | More than one race
Asian Indian | Chinese | Filipino | Japanese | Korean | Vietnamese | Other Asian
Native Hawaiian | Guamanian or Chamorro | Samoan | Other Pacific Islander

Ethnicity? Mexican, Mexican American, Chicano/a | Puerto Rican | Cuban | Other Hispanic, Latino/a | Not Hispanic, Latino/a

Are you a veteran? Yes | No **Primary Language?** English | Spanish | Other _____ Need interpretation services? Yes | No

Are you a public housing resident? Yes | No **If yes, which housing development?** _____

Are you homeless? Yes | No **If yes, what is your status?** Street | Doubling Up | Transitional Housing | Shelter _____

Is your main employment in agriculture on a seasonal basis (Seasonal Agricultural Worker)? Yes | No

Do you move (migrate) through the year for agricultural work (Migratory Agricultural Worker)? Yes | No

Sexual Orientation? Straight/Heterosexual | Lesbian or Gay | Bisexual | Other | Don't Know | Choose not to disclose

Gender Identity? Male | Female | Transgender/Female-to-Male | Transgender/Male-to-Female | Other | Choose not to disclose

Acknowledgements

1) I voluntarily consent to receiving services at Christ Community Health Services Augusta (CCHSA). I give permission to all CCHSA Staff to use diagnostic and procedures they deem necessary for proper medical, dental, behavioral and spiritual care.
2) I assign the payment of claims on my behalf to CCHSA. I understand some of the services I receive may not be covered by my third-party payor (Medicare, Medicaid, other insurance), and I am responsible for paying these amounts.
3) I understand payment in full is expected before I receive services at CCHSA. This includes payment of all service fees, copays, and/or coinsurance amounts as discounted based on my fee discount eligibility.
4) I understand CCHSA will not write prescriptions for narcotics at a patient's first appointment. I further understand CCHSA Providers do not guarantee that they will continue a narcotic prescription.
5) I understand CCHSA may discharge me as a patient for cause, or if I do not see a Provider at CCHSA in a 3-year period.
6) I understand Christ Community is an integrated care system, meaning that all providers work together to coordinate my care. I understand all my visit notes are part of my medical record. This means that other providers at Christ Community who care for me may have access to this information.
7) Some services at Christ Community Health may include the use of telemedicine equipment and interaction with providers who are not physically onsite. These services are conducted via secure lines and are not videotaped, routed through the internet, or saved in any means.

I affirm all information provided in this Patient Information form is true and accurate to the best of my knowledge.

_____ _____ _____

SIGNATURE of Patient or Patient's Parent/Guardian PRINTED NAME of Patient or Patient's Parent/Guardian DATE

Protection of Health Information – For Minors

Patient Name	Last	First	Middle Initial	Date of Birth

If the patient is an emancipated minor, please tell CCHSA Staff and complete the Adult PHI Form.

Christ Community Health Services Augusta (CCHSA) is allowed to share the Patient's Protected Health Information (PHI) with only the people you list below. This PHI includes but is not limited to the Patient's health history, list of medicines, and lab results. These people will also be allowed to pick up the Patient's prescriptions.

PATIENT'S PARENT(S) or LEGAL GUARDIAN(S)				May we leave a message on this person's phone?
Full Name	Date of Birth	Phone Number(s)	Relationship to Patient	Yes | No
Full Name	Date of Birth	Phone Number(s)	Relationship to Patient	Yes | No

☐ IF SOMEONE OTHER THAN A PARENT/LEGAL GUARDIAN WILL BRING YOUR CHILD TO APPOINTMENTS, call about your child's health, and/or PICK UP PRESCRIPTIONS for your child, check this box.
(Please complete the **Consent by Proxy** form)

EMERGENCY CONTACT (other than a parent or legal guardian) *Listing someone here does not give them permission to bring your child to appointments or to pick up prescriptions, etc.*				May we leave a message on this person's phone?
Full Name	Date of Birth	Phone Number(s)	Relationship to Patient	Yes | No

CCHSA uses Health Information Exchanges (HIEs) to share PHI with other doctors' offices, hospitals, pharmacies, etc. HIEs make it easier and faster for all your healthcare providers to have access to your health information so they can give you the best care possible. Only Network Participants of HIEs who are relevant to a patient's care are allowed to share and view patients' PHI through HIEs.

You have the right to ask that we do not share your PHI through HIEs. Whether you participate will not affect your access to services at CCHSA. If you do not want your PHI to be shared through HIEs, please check this box.

☐ Opt Out

Acknowledgements

1) I have been given the chance to review the Notice of Privacy Practices.
2) I give permission for CCHSA to use and to share the Patient's PHI with necessary third-parties for payment, for treatment, and for general healthcare operations.
3) I give permission for CCHSA to share the Patient's PHI and to release the Patient's prescriptions to each of the parents/legal guardians listed above. I have the legal right to give this authority.
4) I understand that I have the right to restrict how CCHSA shares PHI and I can cancel this permission any time.

_____	_____	_____
SIGNATURE of Patient's Parent or Legal Guardian	PRINTED NAME of Parent or Legal Guardian(s)	DATE

CHRIST COMMUNITY HEALTH

Acct#_____

Application for Fee Discounts

Patient Name: _____ Date of Birth: _____

Check if Declining Discounts:

☐ *I Decline all Sliding Fee Discounts. I have received information about available discounts and understand that I can apply anytime in the future.*

List individuals who are usually, primarily, and collectively dependent upon the same Household/Family Income. All individuals included in the calculation of Household/Family Size must live together most of the time. No individual may be considered a member of more than one Household/Family.

Name and Date of Birth	Relation	Income	Week/Month/Year	Christ Community Patient? (circle)
	self			Yes
				Yes/No
				Yes/No
				Yes/No
				Yes/No
				Yes/No
				Yes/No
				Yes/No

(Continue on separate sheet if necessary)

Provide verification of income for each household member as available. If income verification is not available, please complete Self-Attestation form.

CHRIST COMMUNITY HEALTH

Acct#_____

Examples of income below and acceptable proof of income (only one document needed for each income source):

- Salaries & wages (pay stub, cash app, tax form, letter from employer, Self-Attestation form, etc.)
- Self-employment income (tax form, Self-Attestation form, etc.)
- Retirement, including pensions and social security (Benefit Statement, deposit receipt, etc.)
- Unemployment income (Benefit statement, pay stub)
- Workers' compensation, disability, or other related income (benefit statement, pay stub)
- Child support and alimony received (receipt, benefit statement, bank statement, court document.

If applying for discounts, I understand that by signing below I attest that this information represents my household size and income to the best of my ability. I also understand that these discounts apply only to services rendered while I have an active Sliding Fee Discount. If documentation is returned after a visit within two weeks for a new patient, two weeks of a new application, or two weeks from a renewed application, discounts will be applied up to that two-week period. Also, I understand that all applicable payments are expected at the time of service. New applicants and renewing patients (once a year) may only be required to pay a nominal fee at time of service if application for discounts is pending.

Printed Name_____

Signature: _____

Date: _____

Office Use Only: Approved/Not Approved

Pt Access Rep Signature: _____

Printed Name: _____

ACTIVE SLIDING FEE LEVEL DATE RANGE _____

LEVEL: A B C D E

No-Show Policy Acknowledgement

Your healthcare 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 care for all of our patients, please be aware of and follow the Appointment/No-Show Policy.

Keeping Scheduled Appointments & Arriving Early

We will do our best to remind you of your upcoming dental appointment by phone, mail, or email. But it is *your responsibility to remember your appointment date and time*.

You are required to arrive 20-30 minutes *before* your scheduled appointment time. If you cannot make it or think you will be late to your scheduled appointment, please let us know *as soon as possible*. Notification after 3:00 pm the business day before the appointment is too late and is considered a no-show. If you are more than 5 minutes late, we might require you to be re-scheduled. If you are having a hard time finding transportation, please let us know. We might be able to connect you to resources that can help.

What is considered a "No-Show"?

- A no-show is someone who does not arrive for their appointment on the day of the appointment or does not notify the office before 3:00 pm the business day before the appointment.

What happens when I "No-Show" my appointment?

When you don't come to your appointment, you take an appointment time away from someone else who could have used it. **Because there are so many people in our community who do not have access to quality medical and dental services, *"No-Shows" are taken very seriously*.**

New Patients:
If you No-Show your first dental appointment, you will not be allowed to schedule another appointment for one year.

Established Patients:
If you No-Show 2 appointments in a 12-month period, you may not be allowed to schedule another appointment for one year.
Patients under age 18 may be granted an exception to the No-Show Policy at the discretion of a dental provider.

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

_____ _____

Patient or Patient's Parent/Guardian Signature Date

General Dental Consent Form

Patient Name	Last	First	Middle Initial	Date of Birth

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.

General Dental Consent Form

CHRIST COMMUNITY HEALTH

Consent:

I understand that dentistry is not an exact science, therefore: reputable clinicians cannot 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 that 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.

_____	_____	_____
SIGNATURE of Patient or Patient's Representative	PRINTED NAME of Patient or Patient's Representative	DATE