SUMMIT COUNTY PUBLIC HEALTH
1867 WEST MARKET STREET · AKRON, OHIO 44313 · 330-923-4891 · WWW.SCPH.ORG

Thank you for choosing Summit County Public Health as your dental health care provider. We are committed to building a successful doctor-patient relationship with you and your family. Your clear understanding of our patients' financial responsibility is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc.).

Co-pays

Patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at time of check-in. We accept cash, check, or credit cards. Absolutely no post-dated checks will be accepted.

Insurance Claims

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Self-pay Accounts

Self-pay accounts are patients without insurance coverage or patients without an insurance card on file with us. It is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with information provided to us by the patient, the patient will be considered self-pay until the correct information is provided. Self-pay patients will be required to make payment at time of service.

Sliding Fee Accounts

If you are Summit County Resident are uninsured and have a low income, you may qualify for a sliding fee discount for your dental services. This program is made available by Summit County Public Health to provide dental care for people who otherwise may be unable to afford it. The discount applies only to office visits provided by our clinic staff; lab services billed by our clinic may be reduced but will not be charged at less than our cost.

If you wish to qualify for the sliding fee, you must show proof of gross annual income for all family members living in your household.

If you appear to be eligible for Medicaid, we will assist you with the application. Eligibility for the sliding fee discount program will be re-assessed if you are denied. Failure to comply with the Medicaid application process will cause you to be ineligible for our sliding fee discount program.

Patient/Authorized Representative Signature _____ **Date** _____

SUMMIT COUNTY PUBLIC HEALTH DENTAL SERVICES

PATIENT INFORMATION

To assist us in serving you, please complete the following confidential form.
The information provided is important to dental health.

Last Name _____ **First Name** _____ **Preferred Name** _____

Age _____ **Birth date** _____ **Male** ☐ **Female** ☐ **Soc. Sec #** ___/___/____

Parent/Guardian _____ **Phone Number** _____ **Alt. Phone** _____

Mailing address _____ **City** _____ **State** _____ **Zip** _____

Emergency Contact _____ **Phone No.** _____ **Relationship** _____

How did you hear about our clinic? ☐ **Internet** ☐ **Bus Sign** ☐ **Referral** ☐ **Other**

INSURANCE INFORMATION

Dental Insurance Yes ☐ **No** ☐

If no coverage, would like to speak to someone about Medicaid Services? Yes ☐ **No** ☐

PRIMARY INSURANCE INFORMATION:

Dental Insurance Co. _____

Group number _____ **Member ID number** _____

SECONDARY INSURANCE INFORMATION:

Dental Insurance Co. _____

Group number _____ **Member ID number** _____

PLEASE TURN OVER AND COMPLETE REVERSE SIDE

I authorize Dr. Jennifer Kale and/or such associates or assistants as she may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an unexpected reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness and temporary or rarely permanent numbness.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I understand that placement of fillings may render the involved teeth sensitive to hot and cold temperatures and/or pressure for an extended period of time.

I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

_____ _____

Client/Guardian Signature **Date**

Acknowledgment of Privacy Practice

I, _____, agree that I have been offered copy of the Notice of Privacy Practices.

_____ _____

Client/Guardian Signature **Date**

MEDICAL HISTORY

Patient Name_____ **Preferred Name** _____ **DOB** _____

Physician's Name _____ **Phone**_____ **Last visit** _____

Current Health Status Good ☐ Fair ☐ Poor ☐

Are you under a physician's care now? ☐ No ☐Yes If yes, please explain_____
Do you smoke or chew tobacco? ☐ No ☐Yes

Do you wear contact lenses? ☐ No ☐Yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ No ☐Yes

WOMEN ONLY

Are you pregnant or think you may be pregnant? ☐ No ☐ Yes

Are you nursing? ☐ No ☐ Yes

Are you taking birth control? ☐ No ☐ Yes

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

☐ No ☐ Yes	Anemia	☐ No ☐ Yes	HIV/AIDS
☐ No ☐ Yes	Asthma	☐ No ☐ Yes	Hypoglycemia
☐ No ☐ Yes	Cancer/Chemotherapy	☐ No ☐ Yes	Joint Replacement or Implant
☐ No ☐ Yes	Chest Pains	☐ No ☐ Yes	Kidney Problems
☐ No ☐ Yes	Chronic Hepatitis	☐ No ☐ Yes	Pacemaker
☐ No ☐ Yes	Diabetes	☐ No ☐ Yes	Psychiatric Problems
☐ No ☐ Yes	Drug/Alcohol Abuse	☐ No ☐ Yes	Severe Headaches
☐ No ☐ Yes	Eating Disorders	☐ No ☐ Yes	Sexually Transmitted Disease
☐ No ☐ Yes	Epilepsy/Seizures/Fainting	☐ No ☐ Yes	Shingles
☐ No ☐ Yes	Fever Blister	☐ No ☐ Yes	Sickle Cell Disease
☐ No ☐ Yes	Heart Attack/Stroke	☐ No ☐ Yes	Sinus Problems
☐ No ☐ Yes	Heart Murmur	☐ No ☐ Yes	Stomach Ulcers
☐ No ☐ Yes	Heart Surgery	☐ No ☐ Yes	Swelling of Feet, Ankle & Hands
☐ No ☐ Yes	Hemophilia/Abnormal Bleeding	☐ No ☐ Yes	Thyroid Problems
☐ No ☐ Yes	High/Low Blood Pressure	☐ No ☐ Yes	Tuberculosis

Are you presently taking any medications prescribed by a physician or dentist? ☐ No ☐ Yes
If yes, please list: _____

Do you take any Blood Thinners (Aspirin, Warfarin/Coumadin, Plavix, Xarelto, Pradaxa, etc.)? _____

Do you need to be pre medicated prior to any dental treatment? ☐ No ☐ Yes If yes, for what condition _____

Do you have an allergy to any of the following? ☐ Latex ☐ Penicillin ☐ Aspirin ☐ Sedatives ☐ Erythromycin
☐ Iodine ☐ Sulfa Drugs ☐ Tetracycline ☐ Dental Anesthetics ☐ No Known Drug Allergies

For Office Use Only
Dentist Reviewed Initials/Date _____ DH/DA Reviewed Initials/Date_____
Dentist Reviewed Initials/Date _____ DH/DA Reviewed Initials/Date_____
Dentist Reviewed Initials/Date _____ DH/DA Reviewed Initials/Date_____
Dentist Reviewed Initials/Date _____ DH/DA Reviewed Initials/ Date_____

DENTAL HISTORY

Former Dentists Name _____ **Phone Number** _____

Current Dental Health ☐ Good ☐ Fair ☐ Poor What is the reason for today's visit _____

How often do you brush your teeth? _____ How often to you floss your teeth? _____

Is your drinking water fluoridated?	☐ No	☐ Yes
Are you under any unusual stress at home or work?	☐ No	☐ Yes
Do you experience stress when you visit the dentist?	☐ No	☐ Yes
Have you experienced jaw problems?	☐ No	☐ Yes
Do you have frequent headaches?	☐ No	☐ Yes
Do your gums ever bleed while brushing or flossing?	☐ No	☐ Yes
Do you clench or grind your teeth?	☐ No	☐ Yes
Do you bite your lips or cheeks frequently?	☐ No	☐ Yes
Do you have any sores or lumps in our near your mouth?	☐ No	☐ Yes
Are your teeth sensitive to (hot, cold, sweet, sour) liquids or foods?	☐ No	☐ Yes
Does food tend to become caught between your teeth?	☐ No	☐ Yes
Do you feel pain to any of your teeth?	☐ No	☐ Yes
Do you wear dentures or partials?	☐ No	☐ Yes
Have you had any neck, head, or jaw injuries?	☐ No	☐ Yes
Have you had any difficulty with extractions in the past?	☐ No	☐ Yes
Have you had nay prolonged bleeding following an extraction?	☐ No	☐ Yes
If possible would you like to keep your natural teeth?	☐ No	☐ Yes

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications, can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

_____ _____

Client/Guardian Signature **Date**

For Office Use Only
Dentist Reviewed Initials/Date _____ DH/DA Reviewed Initials/Date_____
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Summit County Public Health

1867 West Market Street ♦ Akron, Ohio 44313
Phone: (330) 923-4891 ♦ Toll-free: 1 (877) 687-0002 ♦ Fax: (330) 923-7558
www.schd.org

DENTAL CLINIC
CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours notice, we are unable to offer that slot to other people.

Clients arriving more than 15 minutes late for an appointment may be asked to reschedule and/or may be considered a no show. Late arrival and cancelling with less than 24 hours notice may be considered no-showing an appointment.

Our time is valuable and so is yours. If you're late for your appointment, you lose that time. Three (3) missed appointments without giving a 24 hours notice to cancel you will be unable to schedule an appointment for 6 months. Clients may be able to call for availability of a same day appointment. You may call each day to check for open appointment times.

Every effort will be made to provide ongoing dental care to all clients of Summit County Public Health Dental Clinic. This dental practice does not discriminate in providing care to a patient due to race, color, sex, religion, national origin, age, handicap, or any other factors prohibited by law.

Please sign that you have read, understand and agree to this Cancellation and No Show Policy.

_____ _____

Client Name (Please Print) **DOB**

_____ _____

Signature of Client or Patient Representative **Date**

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Last Name _____ First Name _____

Date of Birth: _____ Phone Number _____

PATIENT CONTACT DIRECTIVES

Patient Privacy Directives
In our efforts to comply with the Health Insurance Portability and Accountability Act (HIPAA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends and co-workers.

Do we have permission to:

Contact you and/or leave messages on your home phone or cell phone to discuss appointments and treatments?

□ Yes □ No If No, please provide a number we may leave messages regarding your appointments and/or treatments. _____

Do you have any other specific instructions/requests about how we should communicate with you or others regarding your appointments and/or treatments _____

_____

I acknowledge that all information above is accurate. You must inform us **in writing** of any changes in your directives.

_____ _____

Signature Date

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Meaningful Use Questionnaire

We would like to thank you for taking time to complete this short questionnaire. We apologize for any inconvenience. Due to recent government initiatives to promote the use of an electronic health record, and in compliance with Meaningful Use, the reporting of the patient's racial background, ethnicity, and preferred language, is now a requirement. Please complete the following information regarding the patient that is being seen today.

If you are uncomfortable answering the questions, you may indicate, "Refuse to Report".

Patient Name: _____ DOB : _____

Email: _____

Preferred Pharmacy/Address _____

Whenever possible, we will be using electronic prescribing which allows us to view the external history of your prescriptions. Do You Approve (required)? Yes ☐ No ☐

Please check the box next to the answer that best describes each category:

Gender:
Male ☐
Female ☐

Smoking:
Never smoked ☐
Light smoker ☐
Heavy smoker ☐
Ex-smoker ☐

Height _____

Weight _____

Race:
American Indian or Alaska Native ☐
Asian ☐
Native Hawaiian or Other Pacific Islander ☐
Black or African American ☐
White ☐
Hispanic ☐
Other Race ☐
Unreported/Refused to Report ☐

Language:
English ☐
Nepali ☐
Spanish ☐
Karen ☐
Other ☐_____

Ethnicity:
Hispanic or Latino ☐
Not Hispanic or Latino ☐
Refused to Report ☐

Patient/Guardian Signature_____ Date _____