



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.*

Patients Name _____ Preferred Name _____ Age _____

Birth date _____ Male _____ Female _____ Soc. Sec # _____

Parent/Guardian _____ Home phone _____ Work phone _____

Mailing address _____ City _____ State _____ Zip _____

Emergency Contact _____ Phone No. _____ Relationship _____

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

MEDICAL HISTORY

Patients Name _____ DOB _____

Your child's overall health as well as any medications that your child takes could have an important inter-relationship with the dental care your child receives. Please answer the following questions completely.

Child's Health History

Child's Physician _____ Address _____
City, State, Zip _____ Phone Number _____

Previous Hospitalizations/Surgeries/Serious Illnesses? _____

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs, medicines or other substances? No Yes

Penicillin Novocain Latex Other _____

Is your child current with their immunizations? No Yes

Has your child ever had any of the following?

- | | | | |
|------------------------------------------------|------------------------------------------------------------|--------------------------------------------------|-------------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Stomach, liver or kidney problems | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Handicaps/Disabilities | <input type="checkbox"/> Convulsions/Epilepsy | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Heart Murmur | | <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> No medical conditions | | | |

Please list any medications your child is currently taking: _____

Has your child had a persistent cough or throat clearing not associated with known illness (lasting more than 3 weeks)? 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.

Parent/Guardian Signature

Date

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

Child's Dental History

How often does your child brush? _____ Floss? _____

Is your child's water fluoridated? No Yes Is your child taking fluoride supplements? No Yes

Does your child:

Suck thumb/finger..... No Yes Bite/chew nails..... No Yes

Suck/bite lip..... No Yes Grind teeth..... No Yes

Chew hard objects (pencils,etc) No Yes Clench Jaws..... No Yes

Previous Dentist _____ Phone Number _____

Address _____ Last Visit _____

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.

Parent/Guardian Signature

Date

Acknowledgment of Privacy Practice

I, _____, agree that I have received a copy of the Notice of Privacy Practices.

Parent/Guardian Signature

Date



Summit County Public Health

1867 West Market Street ♦ Akron, Ohio 44313-6901
Phone: (330) 923-4891 ♦ Toll-free: 1 (877) 687-0002 ♦ Fax: (330) 923-7558

Date: _____

I _____ Parent/Legal Guardian (circle one)

of _____ consent to having my child assessed
and/or treated for services at Summit County Public Health without my being present.

The following individuals are permitted to bring my child in for services:

1. _____
Name Relationship
2. _____
Name Relationship
3. _____
Name Relationship

Signature of Parent/Legal Guardian

Copy of Drivers License/State Issued ID confirmed and placed in minor child's clinic
chart: Yes No (circle one) _____
Initials of clinic staff

Reviewed by: _____

Date: _____



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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



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** _____