.Patient Name:

First | Middle/Maiden | Last

Address:

Street | City | State | Zip

Phone # | Work # | Cell #

*IF A MINOR PLEASE LIST PARENTS SS#

Social Security # | Birthdate:

Medicaid # | Medicare #

Race: | Sex: | County of Residence:

If married, list name of spouse:

If filling out this form for a child, complete the following:

List name of parents:

Mother | Father

*Clay County Health Department asks all patients to provide social security numbers to uniquely identify each patient. Provision of your number is voluntary. Your number will be kept confidential in accordance with state and federal laws that protect the privacy of health information. The health department is legally authorized to use patient social security numbers for the purposes listed on the back of this form.

PUBLIC HEALTH DEPARTMENT

345 Courthouse Dr.
Hayesville, NC 28904
Phone: 828-837-1397

Welcome to the Clay County Dental Program. We are glad you have scheduled an appointment with our staff. Oral healthcare is a priority. Regular dental visits every 6 months, including examinations, cleanings, fluoride treatments, dental sealants, and fillings are important to keep your teeth healthy. Maintaining your appointment time is an important piece to prioritizing your dental care. Valuable time has been reserved for services. A missed appointment results in lost time which could be used for another patient waiting to receive treatment. Below is our *"Broken Appointment/ Late Cancellation Policy".*

BROKEN APPOINTMENT/CANCELLATION POLICY

We encourage patients to be at least 15 minutes early for appointments, to ensure that any paperwork or chart updates can be completed in a timely manner. It is the patient's responsibility to update any changes regarding phone number or addresses. Failure to make contact via phone/mailing may result in lost contact attempts, leading to missed dental appointments. We do require a 24-hour advanced notice when cancelling an appointment. If you fail to show for a scheduled appointment or fail to give 24 hours advance notice for **TWO** appointments within 1 year, you will be dismissed from the dental program.

Also, confirmations are required by 2:00 pm the day before the scheduled appointment date. Failure to confirm may lead for a loss in appointment time. Patient can leave a message to confirm appointment on the voicemail box if calling outside of normal business hours.

*Parents with more than 2 children will only be able to schedule 2 minors per visit.

EMERGENCY CARE

Dental clients who have been dismissed from the clinic for either a broken appointment or cancellation reasons will be notified by certified letter and will be seen for EMERGENCY care only for 30 days from the date of the dismissal letter.

CONSENT TO TREATMENT

I hereby give consent to the Clay County Health Department Dental Program to provide treatment to: ______________________________ (check one) ☐ myself, ☐ my child, ☐ my ward; those procedures and treatments, including local anesthesia, which may be deemed necessary. I consent to any x-ray, examination, anesthetic, or dental treatment rendered under the general, director or indirect supervision of the dentist and his/her associates and/or staff members, as he/she may deem necessary.

This authorization will remain in effect until canceled in writing by myself.
I have read the above policy and agree to abide by it and consent for treatment.

Print Name: ____

Signature: ____________________________________ Date: ____________

Patient: Yes/No (Circle One)
Relationship to patient: ____

Witness: ____ Date: ____________

345 Courthouse Dr. Hayesville, NC 28904
Phone: 828-837-1397
FAX: 828-837-1568

PUBLIC HEALTH DEPARTMENT

CLAY COUNTY DENTAL PROGRAM

Parents/Guardians in Treatment Rooms with Children

Here at the Clay County Dental Clinic the dental care and safety of your child is priority. Our staff is highly trained and qualified to treat your child and their individual needs. We also need your help to ensure that we can serve your child in the best way possible. The dental clinic staff needs parents/guardians to follow these procedures:

- Only ONE parent/guardian is allowed to accompany their children into the treatment area for initial exam. This gives the parent/guardian the opportunity to meet the dental staff and allow the dentist to discuss any dental findings or individual treatment needs of your child.
- Other children/siblings/family members are to remain in the waiting room during the visit. *Children in the waiting room will have to be accompanied by an adult.
- The clinician will assess a patient's potential ability to tolerate and/or cooperate for dental procedures during initial patient assessment.
- If at any time during a visit the patient becomes uncooperative, and the dentist feels that it would be in the patient's best interest, it may be necessary to ask the parent to be seated in the waiting area. If this should occur, the dentist will meet with you at the end of the visit to discuss any diagnosis, treatment, or other pertinent information with you.
- If your child is having a restorative procedure, such as a filling, you will be expected to remain in the waiting room, *unless* an exception has been made. If your presence is necessary, a staff member will come escort you at that time.
- Parents/Guardians in treatment areas must remain "silent observers". Children are easily distracted and need to focus on instructions given to them by the dental staff.
- Parents/Guardians in treatment areas must exercise caution as to remain out of the clinician's way and avoid touching the equipment during the visit. Maintaining a sterile and safe environment is essential to protecting your child during their treatment at our office.
- When in the treatment area, cell phones ARE NOT PERMITTED. You are welcome to utilize your phone in the waiting area.
- When in the treatment area, food and drink ARE NOT PERMITTED. This helps to further ensure high infection control standards.

345 Courthouse Dr. Hayesville, NC 28904
Phone: 828-837-1397
FAX: 828-837-1568

The dental experience is based on trust and grows with each visit. Our goal is for you and your child/children to trust our staff and feel comfortable. As your child grows and becomes more comfortable with receiving dental care, we recommend that you give your child an opportunity to accomplish this independently. We aim to assist your child to take pride in their dental health and investing in themselves for a lifetime to come.

If you have any questions, please reach out *prior* to your scheduled appointment.

Thank you for choosing the Clay County Dental Clinic!

______________________________________ ________________

Childs name Date of Birth

______________________________________ ________________

Signature of Parent/Guardian Date

____

Print name of Parent/Guardian

______________________________________ ________________

Dental Clinic Witness Signature Date

PUBLIC HEALTH DEPARTMENT

Clay County Health Department
A Division of North Carolina Public Health

PATIENT NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996-(HIPAA),
Health Information Technology for Economic and Clinical Health Act (HITECH Act), and associated regulations and amendments

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice or if you need more information, please contact:

Clay County Dental Clinic
(828) 837-1397
345 Courthouse Drive
Hayesville, NC 28904

ABOUT THIS NOTICE

We understand that health information about you is personal and we are committed to protecting your information. We create a record of the care and services you receive at the Clay County Dental Clinic. We need this record to provide care (treatment), for payment of care provided, for health care operations, and to comply with certain legal requirements. This Notice will tell you about the ways in which we may use and disclose health information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of health information. We are required by law to follow the terms of this Notice that is currently in effect.

WHAT IS PROTECTED HEALTH INFORMATION ("PHI")

PHI is information that individually identifies you. We create a record or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse that relates to:
• Your past, present, or future physical or mental health or conditions,
• The provision of health care to you, or
• The past, present, or future payment for your health care.

HOW WE MAY USE AND DISCLOSE YOUR PHI

We may use and disclose your PHI in the following circumstances:
• **Treatment.** We may use or disclose your PHI to give you treatment or services and to manage and coordinate your care. For example, your PHI may be provided to a dentist or other dental care provider (e.g., an oral surgeon or orthodontist, etc.) to whom you have been referred to ensure that the dentist or other dental care provider has the necessary information to diagnose or treat you or provide you with a service.
• **Payment.** We may use and disclose your PHI so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your dental insurance plan may undertake before it approves or pays for the dental care services, we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.
• **Health Care Operations.** We may use and disclose PHI for our health care operations. For example, we may use your PHI to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information, internally, to dentists, dental assistants, hygienists, and other authorized personnel for quality improvement and learning purposes.
• **Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services.** We may use and disclose PHI to contact you to remind you that you have an appointment for dental services, or to contact you to tell you about possible treatment options or alternatives or dental benefits and services that may be of interest to you.
• **Minors**. We may disclose the PHI of minor children to their parents or guardians unless such disclosure is otherwise prohibited in programmatic services.
• **As Required by Law.** We will disclose PHI about you when required to do so by international, federal, state, or local law enforcement.
• **To Avert a Serious Threat to Health or Safety.** We may use and disclose PHI when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.
• **Business Associates.** We may disclose PHI to our business associates who perform functions on our behalf or provide us with services if the PHI is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or lab testing services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your PHI.
• **Workers' Compensation.** We may use or disclose PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.
• **Public Health Risks.** We may disclose PHI for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or

activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
• **Abuse, Neglect, or Domestic Violence.** We may disclose PHI to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.
• **Health Oversight Activities.** We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
• **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your PHI to defend ourselves in the event of a lawsuit.
• **Law Enforcement.** We may disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes.
• **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose PHI to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.
• **Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out.**
• **Individuals Involved in Your Care.** Unless you object in writing, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Your Written Authorization if Required for Other Uses and Disclosures

Any of your PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose PHI under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights Regarding Your PHI

You have the following rights, subject to certain limitations, regarding your PHI:
• **Inspect and Copy.** You have the right to inspect, receive, and copy PHI that may be used to make decisions about your care or payment for your care. We have up to **30 days** to make your PHI available to you. You can only direct us in writing to submit your PHI to a third party not covered in this notice.
• **Summary or Explanation.** We can also provide you with a summary of your PHI, rather than the entire record, or we can provide you with an explanation of the PHI which has been provided to you, so long as you agree to this alternative form and pay the associated fees.
• **Receive Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured PHI.
• **Request Amendments.** If you feel that the PHI we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
• **Request Restrictions.** You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment, or health care operations. We are not required by federal regulation to agree to your request. If we do agree with your request, we will comply unless the information is needed to provide emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer. Your request must state the specific restriction requested, whether you want to limit our use and/or disclosure; and to whom you want the restriction to apply.
• **Request Confidential Communications.** You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you.

• Complaints

If you believe your privacy rights have been violated, you may file a complaint with the **Clay County Health Department**, Privacy Officer, at the address listed at the beginning of this Notice.
. **You will not be penalized for filing a complaint.**

PUBLIC HEALTH DEPARTMENT

Clay County Health Department
A Division of North Carolina Public Health

The Clay County Dental Program respects my right to privacy and confidentiality of my PHI. I acknowledge that I have read, and been offered a copy of the *"Notice of Privacy Practices"*.

____
Print Name

__________________________________ ___________
Signature **Date**

Patient: Yes/No (Circle One)
Relationship to patient: ____

Witness: ____ **Date:** _____________________

PUBLIC HEALTH DEPARTMENT

Clay County Health Department
345 Courthouse Dr.
Hayesville, NC 28904
Phone: 828-389-8052
Fax: 828-389-9066

Authorization to Disclose Protected Health Information.

Please PRINT your name (Patient) and other information requested below.	
Name:	Date of Birth:
Address:	
Telephone: ( )	
I authorize **CLAY COUNTY HEALTH DEPARTMENT** to release my PHI as indicated below to the Person(s) named.	

Please PRINT the name(s) of the Authorized Person(s) to whom the Health Plan may release your PHI.	
Name:	Relationship:
Telephone: ( )	
Name:	Relationship:
Telephone: ( )	
Name:	Relationship:
Telephone: ( )	
Name:	Relationship:
Telephone: ( )	

By Signing below, I understand I am authorizing the use/release of my PHI

1. I give my permission for any health care provider to disclose any of my protected health information to the above authorized person(s).
2. I understand that I have the right to revoke this authorization by sending written notice to the office. Revocation will not affect the office's previous reliance on the uses or disclosure in accordance to this authorization.
3. I am aware that I have the right to refuse this authorization.
4. I understand that I may have a copy of this authorization upon request.
5. I am aware that Sexually Transmitted Disease, Family Planning, and Mental Health information will only be discussed with the person that received the care. This information may require additional signed authorization.
6. I acknowledge that I have received a copy of the patient privacy practice notice.

Signature	Date

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Question	Answer	
Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
						Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:__________