NORTH COUNTY HEALTH SERVICES **FACT SHEET** (form 30)

Date	Patient Name (First, Middle, Last)	Patient Account #	Sex	Date of Birth	Social Security

Patient Email	Emergency Contact Name	Emergency Phone #:

Primary Insurance Company	Secondary Insurance Company	Medical Doctor's Name

HOME Address: _____ Apt #: _____ City: _____ Zip: _____

MAILING Address: _____ Apt #: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____ (confirm same as above)

ASSIGNMENT OF BENEFITS

I authorize my healthcare plan/program to reimburse NCHS for all services I receive. I understand I am responsible for any unpaid balances, co-pays, co-insurance, deductibles, and/or any non-covered services.

SLIDING FEE DISCOUNT ELIGIBILITY

To determine if you may qualify for a discount on the health services rendered it is necessary for us to ask personal questions in regards to your family size and income. This information is strictly confidential and cannot be released without your permission. In order to qualify for the Sliding Fee Discount Program you will need to declare your income annually or whenever there is a change in your family size or income. To determine eligibility please **select one** of the following:

☐ I declare that I do not have documentation of my family's current total income or pay stubs today and will provide it at or before my next appointment. I am self-declaring that:
My family's total Gross Monthly Income (amount earned before taxes) is $ _____.
My family size (the number in my household supported by this income), including myself, is _____.

☐ I have provided documentation of my family's current total income or pay stubs which reflects:
My family's total Gross Monthly Income (amount earned before taxes) is $ _____.
My family size (the number in my household supported by this income), including myself, is _____.

☐ I have declined the option to provide information regarding my income and understand that I will not be eligible for discounted services.

MIGRANT/SEASONAL WORKER STATUS

☐ I declare that I or someone in my immediate family earn(s) 51% or more of our income from agricultural work. Agricultural work can consist of seasonal or migrant work.

CONSENT FOR TREATMENT, REFUSAL OF TREATMENT, and DISCLOSURE OF HEALTH INFORMATION

I, (the patient, responsible party, or authorized caregiver), authorize NCHS and its assigned clinical staff to administer and perform all medical treatment, diagnostic, surgical or other services deemed advisable or necessary for healthcare. I understand that I have the right to refuse treatment at any time. I can do so by signing a *REFUSAL OF TREATMENT* form. I also give consent to use and disclose health information necessary for treatment and payment and other healthcare operations.

CONSENT FOR COMMUNICATION

I, (the patient, responsible party, or authorized caregiver), authorize NCHS and its assigned clinical staff to communicate with me via letter, phone call, or text using the information provided above. If I do not wish to be communicated at the address or phone number above, I will ask a NCHS staff to provide me with a *REQUEST TO CHANGE COMMUNICATION PREFERENCES* form.

Date	Patient Name (First, Middle, Last)	Patient Account #	Sex	Date of Birth	Social Security Number

CONSENT FOR ELECTRONIC COMMUNICATION

I, (the patient, responsible party, or authorized caregiver), authorize NCHS and its assigned clinical staff to communicate with me electronically via my MyHealth account. I understand that web based communication is a choice and I may choose to not register with MyHealth.

I give consent to the following when choosing to use MyHealth:

- To receive documents such as visit summaries
- To receive lab results electronically
- To receive secure messages from my provider and assigned clinical staff

PERMISSION TO SHARE HEALTH INFORMATION (Optional)

As your healthcare team, we may need to contact you about your health. We would like to invite you to include members of your family and/or others to be part of your health support group. The people you identify below will be permitted to discuss your health information, including but not limited to appointment information, lab results, medication instructions, and referrals information, and they may be contacted for follow-up purposes in cases when we are unable to reach you. All parties listed below who wish to access your information must provide their information accurately. Designated person must show valid photo ID when in clinic. **To request a paper copy, please complete the AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION form.**

Last Name, First Name	Date of Birth mm/dd/yyyy	Phone #	Address	Relation to Patient	*Sensitive Health Information
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

*Sensitive health information includes mental health treatment information, HIV test results, alcohol or drug treatment information.

PATIENT'S AFFIRMATION OF INFORMATION

I affirm that the information I have provided to North County Health Services (NCHS) is accurate and true to the best of my knowledge. My signature below confirms understand the following:

- If I have provided false information, I may be disqualified from the Sliding Fee Discount Program.
- If any information provided on this form changes, I must advise staff at, or before my next appointment.
- North County Health Services does not provide refunds for professional services rendered.
- I have received a copy of the Notice of Privacy Practices, or a copy was made available to me.

Patient's Signature: _____ **Date:** _____

(Parent, Guardian, Power of Attorney, or Caregiver). Copy of legal documents must be scanned into patient's account.

Relationship to Patient: _____

NCHS USE ONLY		
By signing below, I am certifying that this form is verified for completeness and patient's account has been updated.		
_____ Print Name	_____ Signature	_____ Location

NORTH COUNTY HEALTH SERVICES
we're here for you.

DENTAL HISTORY FORM

PATIENT NAME: _____ **DOB:** _____ **DATE:** _____

DENTAL HISTORY

	Please Circle	
What dental concerns do you have? Describe _____	Yes	No
Do your gums ever bleed? Discuss	Yes	No
Do you have any clicking, popping or discomfort in the jaw joint?	Yes	No
Do your grind or clench your teeth?	Yes	No
Do you smoke or chew tobacco? If yes, how much	Yes	No
Do you have any sores or growths in your mouth?	Yes	No
Have you had trauma to your face or mouth?	Yes	No

MEDICAL HISTORY

Your Doctor's Name: _____ Phone Number _____

When was your last physical? _____ Your last visit to the Doctor? _____

Do you have any medical problems? If yes, describe _____	Yes	No
Have you ever been hospitalized or had a major operation? Discuss _____	Yes	No
Are you taking any medications, pills or drugs? Discuss _____	Yes	No
Do you bleed a lot when cut? _____	Yes	No
Are you taking any Bisphosphonates (Fosamax, Aredia, Boniva, Actonel, Zometa, Aclasta) for Osteoporosis?	Yes	No
Are you allergic to any medications or substances? If yes, please check below _____	Yes	No

☐ Penicillin ☐ Codeine ☐ Latex ☐ Metal ☐ Local Anesthetics ☐ Other _____

WOMEN (Please check): ☐ Pregnant ☐ Nursing ☐ Taking Birth Control Pills

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Do you have or have you ever had any of the following? Please check the appropriate boxes.
*If yes to any of the starred conditions, pre-medication might be required.

	Yes	No		Yes	No		Yes	No
Heart Disease	☐	☐	Liver Disease	☐	☐	Epilepsy or Seizures	☐	☐
High Blood Pressure	☐	☐	Kidney Disease	☐	☐	Sickle Cell Disease	☐	☐
Low Blood Pressure	☐	☐	Hepatitis	☐	☐	Arthritis	☐	☐
Rheumatic Fever*	☐	☐	Asthma	☐	☐	HIV or AIDS	☐	☐
Heart Murmur*	☐	☐	Tuberculosis	☐	☐	Cancer	☐	☐
Heart Valve Problems*	☐	☐	Hemophilia	☐	☐	Radiation Treatment	☐	☐
Heart Surgery*	☐	☐	Blood Disease	☐	☐	Chemotherapy	☐	☐
Heart Pacemaker	☐	☐	Leukemia	☐	☐	Fainting or Dizziness	☐	☐
Angina	☐	☐	Bruise Easily	☐	☐	Drug Addiction	☐	☐
Heart Attack	☐	☐	Diabetes	☐	☐	Transplant	☐	☐
Stroke	☐	☐	Fever Blisters	☐	☐	Artificial Joint*	☐	☐
Psychiatric Care	☐	☐	Herpes	☐	☐	Cortisone Medications	☐	☐

Have you ever had any other serious illness not checked above? Discuss _____	Yes	No
Do you wish to talk to the dentist privately about any problem? _____	Yes	No

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if any of my medicines change, I shall inform the dentist and staff at the next appointment without fail.

Patient Signature (or Parent/Guardian): _____ Date: _____

Review & Signature of Doctor: _____ Date: _____

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT SIGNATURE	B.P.	REVIEWED BY
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____

Hyperlink(s): Dental Registration Form - English; Dental Registration Form - Spanish