WEST CENTRAL DISTRICT HEALTH DEPARTMENT

DENTAL SERVICES ADULT CHECK-IN FORM

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	BIRTHDATE	AGE	PREFERRED PHARMACY
GENDER	RACE	SOCIAL SECURITY #	MARITAL STATUS: MARRIED SINGLE WIDOW DIVORCED		
ADDRESS	CITY	STATE	ZIP	TELEPHONE #	

Please answer the questions below:

HOW DID YOU HEAR ABOUT OUR SERVICES HERE AT WCDHD? **(PLEASE CIRCLE ALL THAT APPLY)**

Radio TV Billboard Physician Friend/Family Postcard Other:_____

Do you have a medical home? YES NO When was the your last exam/physical? _____

Are you current on vaccinations? YES NO Have you received HPV vaccines? YES NO

RESPONSIBLE PARTY INFORMATION, if different than above

LAST NAME	FIRST NAME	MI	BIRTHDATE	SS#
ADDRESS	STATE	ZIP	TELEPHONE#	
PRIMARY INSURANCE		POLICY #	POLICY HOLDER'S NAME & BIRTHDAY	
SECONDARY INSURANCE		POLICY #	POLICY HOLDER'S NAME & BIRTHDAY	

CELLULAR PHONE, TEXT AND EMAIL CONTACT POLICY: By providing us with an email address or telephone number for a cellular phone or other wireless device, you are expressly consenting to receiving communications - including but not limited to prerecorded or artificial voice message calls, text messages, emails and calls made by an automatic telephone dialing system - from us and our affiliates and agents at that number. This express consent applies to each such email and telephone number that you provide to us now or in the future and permits such calls, texts, and emails regardless of their purpose. Calls and messages may incur access fees from your cellular provider. From time to time West Central District Health Department takes photos or video of our programs to use in our marketing materials both in print and on the web. By signing this form, you're giving consent to have your photo used for these purposes. If you do not agree to have your photo used, please call West Central District Health Department and we will make arrangements to exclude your photo from use.

HIPAA: By signing this form, I understand the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly; obtain payment from third-party payers; conduct normal healthcare operations such as quality assessments and physician certifications and that my protected health information may be entered into state or national registries, access to which is restricted to persons who have signed agreements to keep all patient registry information confidential. I have been informed by you and your Notice of Privacy Practices containing a more complete description the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

By signing below, I acknowledge: *The above information is true to the best of my knowledge. I have been educated on the public health dental hygiene scope of services and I have had a chance to ask questions and these have been answered to my satisfaction. I understand I will receive a visual dental exam by a public health dental hygienist with recommendation to have a complete exam by a dentist. I also understand the benefits and risks of public health dental hygiene and ask that services under the scope of a public health dental hygienist be performed to me or the person named below for who I am authorized to make this request. I am aware that if my insurance does not cover the care received I am financially responsible for the balance.*

PATIENT SIGNATURE	DATE

Original: 6/20/2018
Updated: 6/22/2018
Location: Groups/Dental/Forms

WCDHD DENTAL NO SHOW NO CALL POLICY

Twenty-four-hour notice for cancellation of scheduled appointments is required. Failure to do so will result in the following.

1. **1st no show**: Attempt to contact client, communicate WCDHD's no show policy. Note communication in client's electronic record/chart. The Client will be rescheduled as
    - Openings allow; Offered to come in on a walk-in basis, noting to the client that scheduled appointments will be seen first and then any walk-ins if time allows.
2. **2nd no show:** Written notification of WCDHD's no show policy will be mailed to client and communication noted in client's electronic record/chart. Clients with two no shows will only be allowed to seek services at WCDHD as follows.
    - Scheduled as secondary appointment holder, noting to the client that primary scheduled appointments will be seen first and this appointment time is not a guarantee for services; Offered to come in on a walk-in basis if time allows, noting to the client that scheduled appointments will be seen first and then any walk-ins if time allows.

We understand that at times, emergencies arise that are unavoidable, and we will review certain situations on a case-by-case basis.

WEST CENTRAL DENTAL SERVICES POLICY:

- *If you do not have insurance, payment is required the day of service. Payment can be made by cash, credit card/debit card or check, or Pay My Dental Bill @ www.wcdhd.org (WCDHD website)*
- *You may qualify for a payment plan by automatic monthly withdrawal.*
- *Private insurance Co-Pay is due day of service.*
- *We require a 24 hr notice for cancellations.*
- *Any patient 15 minutes late for an appointment may be asked to reschedule.*
- *Please turn cell phone off or silent it when in treatment areas.*
- *We accept MCNA (Nebraska Medicaid) and Private Insurances.*

MEDICAID PATIENTS 21YR AND UP: I understand that I have a maximum of $750.00 in dental services covered by Nebraska Medicaid. If I choose to have services provided that exceed this amount, I will be responsible for payment.

Patient Signature_____ Date_____

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