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.).

Insurance Claims

As a courtesy to you we will gladly process your insurance claim forms. Our responsibility is to provide you with the treatment that best meets your needs, which may not match your care to insurance plan limitations. As such, many routine and necessary dental services are not covered even though you may need those services. Therefore all charges are your responsibility. 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.

Please realize you are financially responsible for all charges incurred, regardless of insurance coverage.

All insurance co-pays and deductibles must be paid at the time service. Also, please be aware past due accounts, over 90 days, will be suspended from scheduling until the past due balance is paid.

Self-pay Accounts

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

Minimum Fee $25.00 per visit. $30.00 for extractions

Sliding Fee Accounts

If you are a Summit County Resident, are uninsured and have a low income, you may qualify for a sliding fee discount for y our 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.

Minimum fee $25.00 per visit $30.00 for extractions

Lab services

If dentures, partial dentures, crowns and/or bridges, retainers, mouth guards or night guards are to be fabricated by a dental laboratory, a 50% deposit will be required at the time of the first impression. The remaining balance is due at the time the prosthesis is cemented or inserted, unless other arrangements have been approved by the dental office.

No show and cancellation 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.

Unfortunately, we do not have the resources to maintain adequate supervision of children. Please refrain from bringing unattended/unscheduled children.

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 let us know if you have any questions or concerns.

Please bring a list of all medications currently taking to your appointment.

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_____ Gender_____ 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_____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I acknowledge that I have been offered copy of the Notice of Privacy Practices.

_____ _____

Client/Guardian Signature Date

CONTACT DIRECTIVES AUTHORIZATION

I authorize you to contact me on my □ home phone_____ □ cell phone_____ regarding appointments and treatment. I understand that I must notify SCPH in writing of any changes in my directives.

_____ _____

Client/Guardian Signature Date

FINANCIAL AGREEMENT

I have read and agree to the Summit County Public Health Financial Agreement.

_____ _____

Client/Guardian Signature Date

Treatment Waiver and Release

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 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 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 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**

CHILD HEALTH & DENTAL HISTORY

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

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

Current Health Status Good □ Fair □ Poor □ Has your child ever been hospitalized? □ **No** □ **Yes, If Yes When and Why?** _____

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

□ **No** □ **Yes**	**Allergies** _____	□ **No** □ **Yes**	**Liver Disease**
□ **No** □ **Yes**	**Anemia**	□ **No** □ **Yes**	**Pregnant**
□ **No** □ **Yes**	**Asthma**	□ **No** □ **Yes**	**Pre-Med**
□ **No** □ **Yes**	**Asperger's/Autism**	□ **No** □ **Yes**	**Psychiatric Problems**
□ **No** □ **Yes**	**Birth Defects**	□ **No** □ **Yes**	**Seizure Disorder**
□ **No** □ **Yes**	**Bleeding Problems**	□ **No** □ **Yes**	**Sickle Cell Anemia**
□ **No** □ **Yes**	**Blood Disorders**	□ **No** □ **Yes**	**STD's**
□ **No** □ **Yes**	**Cancer**	□ **No** □ **Yes**	**Syndrome (specify)**
□ **No** □ **Yes**	**Diabetes**	□ **No** □ **Yes**	**Tuberculosis**
□ **No** □ **Yes**	**Heart Murmur/Defect**	□ **No** □ **Yes**	**Pine Nut or Tree Allergies**
□ **No** □ **Yes**	**Heart Surgery**	□ **No** □ **Yes**	**Other** _____
□ **No** □ **Yes**	**Hepatitis**		
□ **No** □ **Yes**	**HIV/AIDS**		
□ **No** □ **Yes**	**Hyperactivity/ADHD**		
□ **No** □ **Yes**	**Kidney Disease**		

Is your child presently taking any prescription or non-prescription medications? □ No □ Yes
If yes, please list: _____

Does your child have any allergies to medications? □ No □ Yes, **Please list** _____

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

Does your child have an allergy to any of the following? □ Latex □ Penicillin □ Aspirin □ Sedatives □ Erythromycin □ Iodine □ Sulfa Drugs □ Tetracycline □ Dental Anesthetics □ No Known Drug Allergies

Is this your child's first dental visit? □ No □ Yes Reason for today's visit □ Emergency □ Pain □ Check Up

Previous Dentist Name _____ Phone number _____

How often does your child brush their teeth? _____ Floss? _____

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. 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** _____

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Date: _____

I _____ Parent/Legal Guardian (circle one)

of _____ consent to having my child assessed and/or treated for services at the Summit County Public Health Dental Clinic without me being present. I understand that anesthetic may be used for some treatment procedures.

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 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 _____