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.

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**

MEDICAL HISTORY

Patient Name___________________________________ **Preferred Name** _________________ **DOB** _______

Physician's Name _________________________________ **Phone**_______________________ **Last visit** ___________

Current Health Status Good □ Fair □ Poor □

Are you under a physician's care now? □ No □Yes If yes, please explain_________________________________
Do you smoke or chew tobacco? □ No □Yes

Do you wear contact lenses? □ No □Yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? □ No □Yes

WOMEN ONLY

Are you pregnant or think you may be pregnant? □ No □ Yes

Are you nursing? □ No □ Yes

Are you taking birth control? □ No □ Yes

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

□ No □ Yes	**Anemia**	□ No □ Yes	**HIV/AIDS**
□ No □ Yes	**Asthma**	□ No □ Yes	**Hypoglycemia**
□ No □ Yes	**Cancer/Chemotherapy**	□ No □ Yes	**Joint Replacement or Implant**
□ No □ Yes	**Chest Pains**	□ No □ Yes	**Kidney Problems**
□ No □ Yes	**Hepatitis – Type A, B, or C?**	□ No □ Yes	**Pacemaker**
□ No □ Yes	**Diabetes**	□ No □ Yes	**Psychiatric Problems**
□ No □ Yes	**Drug/Alcohol Abuse**	□ No □ Yes	**Severe Headaches**
□ No □ Yes	**Eating Disorders**	□ No □ Yes	**Sexually Transmitted Disease**
□ No □ Yes	**Epilepsy/Seizures/Fainting**	□ No □ Yes	**Shingles**
□ No □ Yes	**Fever Blister**	□ No □ Yes	**Sickle Cell Disease**
□ No □ Yes	**Heart Attack/Stroke**	□ No □ Yes	**Sinus Problems**
□ No □ Yes	**Heart Murmur**	□ No □ Yes	**Stomach Ulcers**
□ No □ Yes	**Heart Surgery**	□ No □ Yes	**Swelling of Feet, Ankle & Hands**
□ No □ Yes	**Hemophilia/Abnormal Bleeding**	□ No □ Yes	**Thyroid Problems**
□ No □ Yes	**High/Low Blood Pressure**	□ No □ Yes	**Tuberculosis**

Are you presently taking any medications prescribed by a physician or dentist? □ No □ Yes
If yes, please list: ____

Do you take any Blood Thinners (Aspirin, Warfarin/Coumadin, Plavix, Xarelto, Pradaxa, etc.)? _____________________

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

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

DENTAL HISTORY

Former Dentists Name ___________________________________ **Phone Number** ________________________

Current Dental Health □ Good □ Fair □ Poor What is the reason for today's visit ____________________

How often do you brush your teeth? ________________ How often to you floss your teeth? _______________

Is your drinking water fluoridated? ………………………………………………… □ No □ Yes
Are you under any unusual stress at home or work? .... □ No □ Yes
Do you experience stress when you visit the dentist? ………………………………. □ No □ Yes
Have you experienced jaw problems? ………………………………………………. □ No □ Yes
Do you have frequent headaches? …………………………………………………… □ No □ Yes
Do your gums ever bleed while brushing or flossing? .... □ No □ Yes

Do you clench or grind your teeth? .... □ No □ Yes
Do you bite your lips or cheeks frequently? ……………………………………….□ No □ Yes
Do you have any sores or lumps in our near your mouth? …………………………… □ No □ Yes
Are your teeth sensitive to (hot, cold, sweet, sour) liquids or foods? …………………□ No □ Yes
Does food tend to become caught between your teeth? ………………………………...□ No □ Yes
Do you feel pain to any of your teeth? …………………………………………………. .□ No □ Yes
Do you wear dentures or partials? …………………………………………………….□ No □ Yes
Have you had any neck, head, or jaw injuries? ……………………………………….□ No □ Yes
Have you had any difficulty with extractions in the past? ……………………………...□ No □ Yes
Have you had nay prolonged bleeding following an extraction? ……………………….□ No □ Yes
If possible would you like to keep your natural teeth? …………………………………□ 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.

____ _______________________

Client/Guardian Signature **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 ____________________