PATIENT NAME: _____ ___ _____ **DOB:**____/____/_____
First MI Last mm/dd/yyyy

Social Security Number: _____-____-_____

Home Phone: _____ Cell Phone:_____

Sex assigned at birth: ☐ Male ☐ Female

Gender Identity:	☐ Male ☐ Female ☐ Transgender Male / Female to Male ☐ Transgender Female / Male to Female ☐ Other ☐ Choose not to disclose
Sexual Orientation:	☐ Lesbian or Gay ☐ Straight (not lesbian/gay) ☐ Bisexual ☐ Something else ☐ Don't know ☐ Choose not to disclose

Address: _____
(Street Address) *(City)* *(State)* *(Zip)*

Mailing Address (if different): _____
(Street Address) *(City)* *(State)* *(Zip)*

Appointment reminders / Confirmations / Special Notices / Sharing Information

To authorize us to send email and/or text messages that may contain your health information, to you or other health care providers, please provide the following information. Email and text messaging are not a completely secure means of communication because they may be addressed to the wrong person or accessed improperly during transmission.

Email to send me information: _____ Phone Number to send me texts: _____

**If you prefer not to authorize the use of email / text messaging we will continue to use U.S. Mail or telephone to communicate with you.*

YOUR PRIMARY CARE DOCTOR IS: _____ ☐ Dr. Royeen ☐ Dr. Curry ☐ Emily Eichelberger NP

YOUR DENTIST IS: _____ ☐ Dr. Watson ☐ Dr. Johnson

PREFERRED PHARMACY IS: _____ @ _____

Ethnicity
☐ Not Hispanic / Not Latino
☐ Hispanic / Latino
☐ Unknown / Not Reported

Race
☐ American Indian/Alaska Native ☐ Asian
☐ Black/African American ☐ White
☐ More than one race ☐ Native Hawaiian
☐ Other Pacific Islander ☐ Declined

Marital Status: ☐ Single ☐ Married ☐ Legally Separated ☐ Divorced ☐ Widowed

Are you a: Student? ☐ No ☐ Yes **Veteran?** ☐ No ☐ Yes **Migrant Worker?** ☐ No ☐ Yes

Are you homeless? ☐ No ☐ Yes

What is the approximate annual household income? _____ Family Size __ ☐ Refused to Report

Does patient need an interpreter? ☐ No ☐ Yes -Spanish / French / Sign Language

Does the parent/guardian need an interpreter? ☐ No ☐ Yes -Spanish / French / Sign Language

Does patient have a Power of Attorney For Healthcare/ Advance Directive / Do-Not-Resuscitate order / Court Ordered Guardian? ☐ No ☐ Yes *If yes please provide us with a copy.

EMERGENCY CONTACT INFORMATION:

NAME: _____

Relationship: _____ Phone Number: _____

PATIENT NAME: _____ ___ _____ **DOB:**____ / ____ / _____
First MI Last mm/dd/yyyy

RESPONSIBLE PARTY INFORMATION *Person to be billed if other than patient

First Name: _____ MI: _____ Last Name: _____ Suffix: ____

Social Security Number: ____ - ___ - _____ Date of Birth: ___ / ___ / ____ Sex: ☐ Male ☐ Female

Address: _____
(Address) *(City)* *(State)* *(Zip)*

Phone Number: _____

All clients have the right to treatment by the Cass County Health Department (CCHD) without discrimination to age, race, color, religion, sex, sexual orientation or national origin.

The above information is true and correct to my knowledge.

I accept full responsibility for my/my child's care and treatment and release the CCHD and staff of any and all liability for any adverse results that may occur due to my refusal to follow the recommended plan of treatment.

I authorize the CCHD to provide service to me and to release necessary information to bill, process and receive payment of Medical / Dental Benefits (private insurance, Medicare, or Medicaid, etc.), for Medical and Professional Services Rendered.

PATIENT RIGHTS AND RESPONSIBILITIES: I understand it is my responsibility to read and follow the information contained in this notice. All clients have the right to treatment by CCHD without discrimination to age, race, color, religion, sex, sexual orientation or national origin.

NOTICE OF PRIVACY PRACTICES: My signature below also indicates that I have been offered a copy of CCHD's "Notice of Privacy Practices." I understand it is my responsibility to ask any questions I may have.

CONSENT TO RELEASE INFORMATION TO DESIGNATED FAMILY MEMBER OR CAREGIVER
The names listed below are allowed to have information released to them from Cass County Health Department with the undersigned consent.

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

☒ **Patient / Parent Signature:**_____ **Date:**_____

*This consent may be revoked at any time upon written request.

PATIENT NAME: _____ ___ _____ **DOB:**_____ / ____ / _____
First MI Last mm/dd/yyyy

ACKNOWLEDGEMENT OF POLICIES AND PROCEDURES

Thank you for choosing Cass County Health / Dental / Behavioral Health Clinic for your medical / dental and behavioral health care. Our staff values your time and we hope you will, in turn, value ours. In order to serve you better we have the following office policies for you to review and sign. Agreeing to these policies will enable us to provide better care to you in a timely and efficient manner.

PAYMENT

- All payments / copays for services performed are due at the time of service
- Eligibility for services under Illinois Medicaid will be determined prior to the start of each visit.
- You must bring your current insurance card for each appointment. If eligibility cannot be verified, you will be required to pay for the service.
- Any services not covered by Medicaid, Medicare and/or medical / dental insurance will be your responsibility to pay.
- A patient with a past due balance will be required to consult with our billing office to set up a payment plan to pay off the past due amount.
- I understand if my account is referred to a Collection Agency I will be responsible for Collection costs incurred.

SLIDING FEE SCHEDULE

- We offer a sliding fee plan to allow patients who have provided proof of income to receive services at an affordable fee. Your fee is determined by the income and size of your family.
- The sliding fee schedule is based on the United States Department of Health and Human Services Guidelines.

APPOINTMENTS

- It is your responsibility to remember your appointment. In order for us to provide a courtesy call, a current contact phone number is required. It is your responsibility to inform us of any changes.
- Staff will call to confirm appointments. You must answer, or call us back within 24 hours, or your appointment will be cancelled.
- If your phone number is disconnected or not updated or your voicemail is not working, your appointment may be filled with another patient.
- New patients will be asked to show up to their appointment 30 minutes prior to the start of their appointment to complete new patient paperwork.

TREATMENT OF MINORS

All minors must be accompanied by a legal guardian or a legal guardian must give written permission for another individual to accompany them by completing the required Proxy Form. Depending on the treatment to be provided a legal guardian may be required to be on site to give informed consent except in cases where minors may seek care as allowed by Illinois state law.

PATIENT CENTERED MEDICAL HOME

A patient centered medical home is a system of care in which a team of health professionals work together to provide all of your health care needs. We use technology such as electronic medical records to communicate and coordinate your care and provide the best possible outcomes for you. You, the patient, are the most important part of the patient-centered medical home. When you take an active role in your health and work closely with us, you can be sure that you're getting the care you need!

I understand and agree to the above written policies.

_____ _____
Signature **Date**

DATE:_____

MEDICAL HISTORY

PATIENT'S NAME:_____ BIRTHDATE:_____

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◊ No ◊ Yes _____

Have you ever been hospitalized or had major operation? ◊ No ◊ Yes _____

Have you ever had a serious head or neck injury? ◊ No ◊ Yes _____

Are you taking any medications? ◊ No ◊ Yes _____

Do you take, or have you taken Phen-Fen, Redux? ◊ No ◊ Yes

Are you or have you ever taken, Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? ◊ No ◊ Yes

Are you on a special diet? ◊ No ◊ Yes

Do you use tobacco? ◊ No ◊ Yes

Do you use controlled substances? ◊ No ◊ Yes

Women, Are you:

Pregnant/Trying to Get Pregnant ◊ No ◊ Yes Taking Oral Contraceptives ◊ No ◊ Yes Nursing ◊ No ◊ Yes

Are you allergic to any of the following?:

◊Aspirin ◊Penicillin ◊Codeine ◊Acrylic ◊Metal ◊Latex ◊Local Anesthetics

◊Food -If yes, please explain:_____

◊Other-If yes, please explain:_____

◊I have no known allergies

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

AIDS/HIV Positive	◊ Yes	Cortisone Medicine	◊ Yes	Hemophilia	◊ Yes	Radiation Treatments	◊ Yes
Alzheimer's Disease	◊ Yes	Diabetes	◊ Yes	Hepatitis A	◊ Yes	Recent Weight Loss	◊ Yes
Anaphylaxis	◊ Yes	Drug Addiction	◊ Yes	Hepatitis B or C	◊ Yes	Renal Dialysis	◊ Yes
Anemia	◊ Yes	Easily Winded	◊ Yes	Herpes	◊ Yes	Rheumatic Fever	◊ Yes
Angina	◊ Yes	Emphysema	◊ Yes	High Blood Pressure	◊ Yes	Rheumatism	◊ Yes
Arthritis/Gout	◊ Yes	Epilepsy or Seizures	◊ Yes	High Cholesterol	◊ Yes	Scarlet Fever	◊ Yes
Artificial Heart Valve	◊ Yes	Excessive Bleeding	◊ Yes	Hives or Rash	◊ Yes	Shingles	◊ Yes
Artificial Joint	◊ Yes	Excessive Thirst	◊ Yes	Hypoglycemia	◊ Yes	Sickle Cell Disease	◊ Yes
Asthma	◊ Yes	Fainting Spells/Dizziness	◊ Yes	Irregular Heartbeat	◊ Yes	Sinus Trouble	◊ Yes
Blood Disease	◊ Yes	Frequent Cough	◊ Yes	Kidney Problems	◊ Yes	Spina Bifida	◊ Yes
Blood Transfusion	◊ Yes	Frequent Diarrhea	◊ Yes	Leukemia	◊ Yes	Stomach/Intestinal Disease	◊ Yes
Breathing Problem	◊ Yes	Frequent Headaches	◊ Yes	Liver Disease	◊ Yes	Stroke	◊ Yes
Bruise Easily	◊ Yes	Genital Herpes	◊ Yes	Low Blood Pressure	◊ Yes	Swelling of Limbs	◊ Yes
Cancer	◊ Yes	Glaucoma	◊ Yes	Lung Disease	◊ Yes	Thyroid Disease	◊ Yes
Chemotherapy	◊ Yes	Hay Fever	◊ Yes	Mitral Valve Prolapse	◊ Yes	Tonsillitis	◊ Yes
Chest Pains	◊ Yes	Heart Attack/Failure	◊ Yes	Osteoporosis	◊ Yes	Tuberculosis	◊ Yes
Cold Sores/Fever Blisters	◊ Yes	Heart Murmur	◊ Yes	Pain in Jaw Joints	◊ Yes	Tumors or Growths	◊ Yes
Congenital Heart Disorder	◊ Yes	Heart Pacemaker	◊ Yes	Parathyroid Disease	◊ Yes	Ulcers	◊ Yes
Convulsions	◊ Yes	Heart Trouble/Disease	◊ Yes	Psychiatric Care	◊ Yes	Venereal Disease	◊ Yes
						Yellow Jaundice	◊ Yes

Have you ever had any serious illness not listed above? ◊ Yes ◊ No

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_____ DATE:_____