700 EAST OAK STREET
CANTON ILLINOIS 61520
Phone: 309-647-1134
Fax: 309-647-9545
Contact Us On The Web At:
www.fultoncountyhealth.com

Astoria Sub-office
309-329-2922

Cuba Sub-Office
309-785-5300

FULTON COUNTY HEALTH DEPARTMENT

An Equal Opportunity Employer and Provider

PATIENT REGISTRATION

First Name: _____ MI _____ Last Name: _____

Birthdate: _____ SEX _____ Age:_____ Home Phone: _____

Address: _____ CellPh: _____

City: _____ State: _____ Zip: _____

Medicaid Id#: _____ Other Insurance: _____

Pharmacy Name and Address: _____

Household Size: _____ Household Annual Income: _____
(determines fee scale for pay clients)

IMPORTANT: PROOF OF INCOME OR CURRENT MEDICAID/ALLKIDS CARD MUST BE PRESENTED AT EACH APPOINTMENT.

RECEIPT OF NOTICE OF PRIVACE PRACTICES

I, (patient name) _____, hereby acknowledge that I received the "Notice of Privacy Practices" from the Fulton County Health Department dated Sept. 10, 2013. I understand that the health department is already authorized to use the information gained to bill me, my insurance company, or any other potential sources of reimbursement, such as government programs in which I am enrolled or qualify for services. I also agree to allow release of treatment and/or appointment information to my child's school if necessary.

_____ (Initial) I have received a copy of Patient Responsibility Flyer and have read and understood it.

_____ _____
DATE SIGNATURE

_____

FCHD: 10/13

FULTON COUNTY HEALTH DEPARTMENT DENTAL CENTER :MEDICAL HISTORY

Patient Name:_____ Birthdate: _____

Dr Name: _____ Dr. Phone _____

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:

Are you under a physician's care now? Y _____ N_____

If yes, please explain: _____

Have you ever been hospitalized or had a major operation? Y _____ N_____

If yes, please explain: _____

Have you ever had a serious head or neck injury? Y _____ N_____

Do you have any screws, pins, plates, artificial valves, etc. in your body? Y _____ N _____ If yes, please explain?

Are you taking any medications, pills, or drugs? Please list all medications currently being taken and why. Please include all Over-the-Counter meds such as vitamins/minerals. Y _____ N_____

_____

Are you confined to a wheelchair? Y _____ N_____

If yes, are you able to transfer by yourself? Y _____ N_____

Do you take or have you taken Phen-Fen, Redux, or Fosamox? Y _____ N_____

Are you on a special diet? Y _____ N_____

Do you use tobacco? Y _____ N_____

Do you use controlled substances? Y _____ N_____

Women: Are you ------ Pregnant/trying to get pregnant Y _____ N_____

Taking oral contraceptives Y _____ N_____

Nursing Y _____ N_____

Are you allergic to any of the following:

Aspirin ____ Penicillin ____ Codeine ____ Acrylic ____ Metal ____ Latex ____

Local Anesthetics ____ Other (please list): _____

PLEASE CONTINUE ON BACKSIDE FOR LIST OF ILLNESSES **Revised 02/2014**

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

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

Have you ever had any serious illness not listed above? ___Y___N If yes, Please explain: _____

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

Rev 4/13

Signature & Date _____

PATIENT RESPONSIBILITY

1. BE ON TIME. Recommend you are here at least 5 minutes BEFORE appt.
2. Always bring STATE ID and medication list in case needed.
3. Only patients allowed in operatories unless < 5 or severe med issues.
4. Proxy MUST be signed in office BEFORE appts to allow someone other than legal guardian to bring child for ANY appointment.
5. Payment due at time of service if not covered by Medicaid.
6. Children under 12 cannot be left unattended in waiting room nor may children go back with parent while parent receiving treatment.
7. Missed or late cancel appts. We require 24 hour notice for cancels.
   A. All future appts cancelled if one appt missed and must be reschedule one at a time
   B. Only one family member at a time scheduled
   C. No after school appts given
   D. New patient given two chances. Established patients -
      Miss one—schedule 3 weeks out
      Miss two—schedule 6 weeks out
      Miss three—12 weeks out
      Miss four—terminated as patient

No proxy in place, no Medicaid verification or ability to pay without prior arrangement, or Late Arrival means we may not be able to see patient and would count as missed appt or late cancel

Fulton County Health Department
700 East Oak Street
Canton IL 61520

Proxy for Medical Treatment and/or Lab Tests

I, _____ of _____
(Parent or Legal Guardian) (Address)

City of _____, County of _____,

State of Illinois, am the parent/ guardian having **legal** custody of _____

_____ A minor, age _____, born _____

_____, _____, who resides with me at the address set forth above. I authorize the following adults, in whose care the minor has been entrusted, and who reside at the following addresses, to consent to physical examinations, assessments, dental procedures (including but not limited to local anesthetic, extractions, xrays) for the minor child at visits to the Fulton County Health Department Dental Clinic.

This authorization will expire 1 year after signing.

NAME	ADDRESS
_____	_____
_____	_____
_____	_____

Date _____ _____
(Signature)

Date _____ _____
(Witness)

Consent to Medical Treatment for Minor Child
By Adult Non-Parent

I am the adult (over 18 years of age) In whose care the minor child,

_____ has been entrusted. I consent to
(Name of Child)
physical examinations, assessments, dental procedures (including but not limited to local anesthetic, extractions, xrays) for the minor child at visits to the Fulton County Health Department Dental Clinic.

DATE

_____ _____, SIGNATURE

_____ ADDRESS

DATE

_____ _____, SIGNATURE

_____ ADDRESS

DATE

_____ _____, SIGNATURE

_____ ADDRESS

DATE

_____ _____, SIGNATURE

_____ ADDRESS

DATE

_____ _____, SIGNATURE

_____ ADDRESS