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

Information Release Form
(HIPAA Release Form)

Name: _____ **Date of Birth:** ____/____/____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/____

Witness:_____ Date: ___/____/_____

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 you mouth, your mouth is 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 or N** (Please circle)

If yes, please explain: _____

Have you ever been hospitalized or had a major operation? **Y or N** (Please circle)

If yes, please explain: _____

Have you ever had a serious head or neck injury? **Y or N** (Please circle)

If yes, please explain:

Do you have any screws, pins, plates, artificial valves, etc. in your body? **Y or N** (Please circle)
If yes, please explain:

Are you taking any medications, pills, or drugs? Please list all medications currently being taken and why. Please include all Ove-the –Counter meds such as vitamins/minerals. **Y or N** (Please circle)

Are you confined to a wheelchair? **Y or N** (Please circle)
If yes, are you able to transfer by yourself? **Y or N** (Please circle)

Do you take or have you taken Phen-Fen, Redux or Fosamax? **Y or N** (Please circle)
Have you ever been given I.V. Bisphosphonates (Zometa, Aredia, etc.?) **Y or N** (Please circle)

Are you on a special diet? **Y or N** (Please circle)
Do you use tobacco? **Y or N** (Please circle)
Do you use controlled substances?
Women: Are you..... Pregnant/ trying to get pregnant? **Y or N** (Please circle)
Taking oral contraceptives? **Y or N** (Please circle)
Nursing? **Y or N** (Please circle)
Are you allergic to any of the following?

Aspirin _____ Penicillin _____ Codeine _____ Acrylic _____ Metal _____ Latex _____
Local Anesthetics _____ other (please list) _____

PLEASE CONTINUE OF BACKSIDE FOR LIST OF ILLNESSESS **REVISED 10/2016**

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	Psychiatric Care	___Y___N
Arthritis/Gout	___Y___N	Frequent Headaches	___Y___N	Radiation Treatments	___Y___N
Artificial Heart Valve	___Y___N	Genital Herpes	___Y___N	Recent Weight Loss	___Y___N
Artificial Joint	___Y___N	Glaucoma	___Y___N	Renal Dialysis	___Y___N
Autism/Behavior Disorder	___Y___N				
Asthma	___Y___N	Hay Fever	___Y___N	Rheumatic Fever	___Y___N
Blood Disease	___Y___N	Heart Attack/Failure	___Y___N	Rheumatism	___Y___N
Blood Transfusion	___Y___N	Heart Murmur	___Y___N	Scarlet Fever	___Y___N
Breathing Problem	___Y___N	Heart Pace Maker	___Y___N	Shingles	___Y___N
Bruise Easily	___Y___N	Heart Trouble/Disease	___Y___N	Sickle Cell Disease	___Y___N
Cancer	___Y___N	Hemophilia	___Y___N	Sinus Trouble	___Y___N
Chemotherapy	___Y___N	Hepatitis A	___Y___N	Spina Bifida	___Y___N
Chest Pains	___Y___N	Hepatitis B or C	___Y___N	Stomach/Intestinal Disease	___Y___N
Cold Sores/Fever Blisters	___Y___N	Herpes	___Y___N	Stroke	___Y___N
Congenital Heart Disorder	___Y___N	High Blood Pressure	___Y___N	Swelling of Limbs	___Y___N
Convulsions	___Y___N	Hives or Rash	___Y___N	Thyroid Disease	___Y___N
Cortisone Medicine	___Y___N	Hypoglycemia	___Y___N	Tonsillitis	___Y___N
Diabetes	___Y___N	Irregular Heartbeat	___Y___N	Tuberculosis	___Y___N
Drug Addiction	___Y___N	Kidney Problems	___Y___N	Tumors or Growths	___Y___N
Easily Winded	___Y___N	Leukemia	___Y___N	Ulcers	___Y___N
Emphysema	___Y___N	Liver Disease	___Y___N	Venereal Disease	___Y___N
Epilepsy/Seizures	___Y___N	Low Blood Pressure	___Y___N	Yellow Jaundice	___Y___N
		Lung Disease	___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

Signature & Date_____

MISSED APPOINTMENT AGREEMENT

We value you as our patient and need your cooperation with keeping appointments so that we can provide your care. Missing or canceling an appointment with less than 24 hours' notice means we are unable to fill this appointment time with another patient who desperately needs care. Our policy requires:

Appointment Confirmation: We will contact you two days before your scheduled appointment to confirm that you will be keeping the appointment. You will have until noon the following day to reach out to us. If a confirmation is not received your appointment will be cancelled without notice.

_____ Initial

Timely Cancellations: If you need to cancel or reschedule your appointment, you must give us at least 24 hours' notice. Cancellations made with less than 24 hours' notice will be considered a missed appointment.

_____ Initial

On Time Arrival: If you are more than 10 minutes late to your appointment, we will need to reschedule you for another time.

_____ Initial

Compliance: Patients are only allowed two missed appointments. After the second missed appointment, you will be placed on "same day" only status. And all scheduled appointments will be canceled. If two "same day" appointments are missed, you will not be scheduled for six months.

_____ Initial

Many patients use Fulton County Dental Clinic's services. Your help in keeping your appointments enables us to provide better and timelier care for all our patients.

_____

Name

_____

Patient/Parent/Guardian Signature Date

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FULTON COUNTY HEALTH DEPARTMENT

PATIENT RESPONSIBILITY

- Always bring your state ID, Insurance card or proof of income for base paying patients.
- Arrive on time! The earlier the better! Patient's later than 10 minutes with be rescheduled and counted as a missed appointment. See below
- Only patients allowed in the operatories unless the patient is under 5 years old or the patient is special needs.
- Payment is due at time of service for base paying patients. See below.
- Children under 12 cannot be left in the waiting room by themselves. In addition, children may not go back to the operatory while the patient is receiving treatment.

PAYMENT AND INSURANCE POLICY

PATIENTS ELIGIBLE FOR THE SLIDING FEE DISCOUNT SCHEDULE (SFDS):

- If a patient fails to provide the necessary documentation of financial eligibility for the SFDS prior to their visit they will be expected to pay the full cost of treatment before receiving care. For this reason patients may choose to receive the minimum necessary services until they can provide proof of income and family size. If the patient later provides documentation showing eligibility for the SFDS at the date of service, the difference will be reimbursed to the patient.
- Exception: For emergency visits patients will not be required to pay prior to receiving dental treatment. However, the patient will be responsible for the full balance and it will remain on their account until they provide eligibility documentation.

*Emergency status will be determined by doctor seeing patient. Emergency status must include swelling, acute infection, fever, hemorrhage and/or trauma.

PATIENTS WITH MEDICAID (STATE DENTAL INSURANCE):

- If patients fail to provide the necessary documentation of Medicaid eligibility prior to their visit they will be expected to pay for the full cost of treatment before receiving care. For this reason patients may choose to receive the minimum necessary services until they can provide proof of income /family size. If patients can provide proof of eligibility later, the difference will be reimbursed to the patient.
- Exception: For emergency visits patients will not be required to pay prior to receiving dental treatment. However, the patient will be responsible for the full balance and it will remain on their account until they can provide proof of insurance.

*Emergency status will be determined by doctor seeing patient. Emergency status must include swelling, acute infection, fever, hemorrhage and/or trauma.

Fulton County Health Dept. Dental Clinic
700 East Oak Street
Canton, IL 61520

PROXY FOR MEDICAL/DENTAL TREATMENT AND /OR LAB TESTS

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

City of_____, County of _____in the

State of Illinois have legal custody of_____,a minor, age_____,born _____who resides with me at set forth address above. I authorize the following adults, **(not parent /guardian),** in whose care the minor child has been entrusted, and who reside at the following addresses. These adults are authorized to give consent to any physical examinations, assessments and dental procedures, including but limited to local anesthetic, extractions and xrays for the minor child's appointments to the Fulton County Health Dept. Dental Clinic.

This authorization expires 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 not limited to local anesthetic, extractions, x-rays) for the minor child at visits to the Fulton County Health Dental Clinic.

Date:

_____ _____, Signature

_____ Address

Date:

_____ _____, Signature

_____ Address

Date:

_____ _____, Signature

_____ Address

Date:

_____ _____, Signature

_____ Address