Dear New Dental Patient,

Thank you for choosing Choptank Community Health System for your dental needs.

This new patient packet needs to be completed and returned to our office ten days prior to your scheduled appointment.

This paperwork will help us to provide you with a successful first visit and assist us to establish a new patient treatment plan.

Please return the completed paperwork to our office. You can also fax the paperwork to our office (fax cover sheet enclosed) or return by mail.

Once the paperwork has been received, reviewed, and approved, you will be contacted to confirm your appointment.

Paperwork that has not been received on time or is incomplete, will result in your appointment having to be rescheduled.

Thank you again for Choosing Choptank Health. We look forward to providing your dental.

If you have any questions please call your Dental Center of choice.

Bay Hundred	410-745-0200
Cambridge	410-228-9381
Denton	410-479-2650
Federalsburg	410-754-9021
Goldsboro	410-634-2380

Sincerely,

Your Dental Team

Choptank Community Health

301 Randolph Street, P.O. Box 660 • Denton, MD 21629 • 410.479.4306 • fax 410.479.1714

Consents and Assignments

PERSONAL REPRESENTATIVE, FAMILY OR OTHER ENTITY AUTHORIZED ACCESS TO PROTECTED HEALTH INFORMATION: Name the persons you are authorizing Choptank Community Health System, Inc. to disclose your protected health information regarding treatment, payment and other healthcare operations in the event you are not available.

____

Name of Authorized Person | Relationship | Phone Number

____

Name of Authorized Person | Relationship | Phone Number

RELEASE OF INFORMATION: I authorize **Choptank Community Health System, Inc**. to release information from my medical record to any person, corporation or agency legally responsible for processing and/or paying of any part of the center's charges and/or professional fees. I also authorize release of healthcare workers/providers/consultants who are involved in my care. Release of information to any other party other than that stated above will require separate authorization.

ASSIGNMENT OF BENEFITS: In the event that I am entitled to benefits arising out of my medical insurance policy or contract of insurance benefits, I assign these benefits to **Choptank Community Health System, Inc**. I also assign benefits payable for physician services to **Choptank Community Health System, Inc**. I further understand that I am responsible for 'non-covered' charges by my insurance and/or for charges incurred without authorization or referral.

CONSENT FOR CARE: I hereby give consent to the providers of **Choptank Community Health System, Inc**. to examine, make an assessment and recommend the appropriate treatment for my condition. I also consent to the collection and testing of specimens required for the diagnostic evaluation of my symptoms/condition.

RIGHTS AND RESPONSIBILITY: I have received and read a copy of **Choptank Community Health System, Inc**. "Notice of Information Privacy Practices" HIPAA Notification.

Printed Name: ____________________________ Date of Birth: ____________________________

Signature: ____ Date: ____________________________

Non-Parental Authorization for Consent to Medical/Dental/Surgical Care and Treatment

I, ____, parent/legal guardian of the child(ren) listed below do hereby give my authorization and consent for the below named authorized person(s) to consent to the medical/dental/surgical care and treatment of my child(ren). I hereby authorize and grant that the below named person(s) has/have permission to sign for any medical/surgical procedures or treatments deemed necessary for the well-being of my child(ren). If the child(ren) presents with someone who is not listed on this form, every attempt will be made to contact the parent/legal guardian. I also understand it is my responsibility to notify CCHS of any changes to authorized persons.
*Well Child Checks will not be conducted without Parent(s) or legal guardian(s) present at time of office visit. **This excludes patients seen in a CCHS School Based Health Center.

I am, by this document, representing that I have the authority to consent for all medical/dental/surgical care and treatment of said child(ren):

_________________________________ _________________________________ ________________
Signature Relationship to child(ren) Date

Child(ren):

____ ____________________________
Name Date of Birth

____ ____________________________
Name Date of Birth

____ ____________________________
Name Date of Birth

____ ____________________________
Name Date of Birth

Person(s) who are authorized to get medical care for the child(ren) listed above:

____ __________ _____________________________
Name Date of Birth Relationship to Child(ren)

____ __________ _____________________________
Name Date of Birth Relationship to Child(ren)

____ __________ _____________________________
Name Date of Birth Relationship to Child(ren)

PATIENT FINANCIAL RESPONSIBILITIES

Thank you for choosing Choptank Community Health System as your healthcare provider. We are committed to providing you with high quality care and ask that you read and sign this form to acknowledge your understanding of our patient financial responsibilities.

Patients Name: **Date of Birth:**

- Please be on time for appointments. If you are more than 10 minutes late, it may be necessary to reschedule your appointment.
- Please give us 24-hour notice if you need to cancel or re-schedule an appointment.
- If you miss three (3) appointments in a twelve (12) month period without notifying our office, you will lose your ability to schedule appointments in advance.
- It is your responsibility to contact us as soon as you change your insurance, name, address or phone number.
- Be knowledgeable of your insurance and pay any applicable co-payment upon arrival. If co-payments are not received upon arrival you will be asked to reschedule your appointment.
- All unpaid balances that are the guarantor's responsibility and are due upon receipt of the bill and due within 30 days unless special payment arrangements have been made with our billing office.
- Any account remaining unpaid after 120 days will be turned over to a collection agency and it will be reported to a credit bureau. The collection agency fee of 35% and attorney fees will be the responsibility of the patient and/or guarantor.
- If you are uninsured, please ask the receptionist for our sliding fee program package which may qualify you for services at a discounted rate. You may also qualify for Medicaid. In addition, Maryland also has a program for uninsured children. If you qualify for the sliding fee program, income verification is needed at the time of the appointment. If we do not receive the required documentation, you will be required to pay a $95 **deposit**. If you provide proof of income within 30 days, you may be eligible for a refund.
- If payment is made by check and it is returned or declined, your account will be charged a return check fee (service charge) of $25.00.

If you have any questions regarding the above patient responsibilities, please feel free to contact our Accounts Receivable Manager at (410) 479-9100 or toll free at (877) 745-2455.

Guarantor________________________________Date:

CCHS Representative:______________________Date:

Choptank Community Health System, Inc.
Oral Health History Questionnaire

Date: ________________________

Patient Name: ____ Age: _______ Date of Birth: ____________________

Social Security Number: ______________________________________ Circle One: Male or Female

Primary Care Provider: ___________________________________ City/State: _______________________Phone: _______________

Allergies (Patient):
Are you allergic to Latex? YES or NO
Are you allergic to any medications? YES or NO
If yes, please list all medications: ____

Medical History (Patient) ☑ ***yes if you have had or currently have any of the following:***

☐ Asthma
☐ Angina/Chest Pain
☐ Anemia/Blood Disorder/Hemophilia
☐ Easy Bruising or Bleeding
☐ Clotting Disorders
☐ Heart Problems
☐ ADD/ADHD
☐ Bipolar Disorder
☐ Developmental Problems
☐ Breathing Problems/COPD/Emphysema
☐ Diabetes
☐ Cancer
☐ High Blood Pressure
☐ Thyroid Disorder
☐ Tuberculosis
☐ Vascular Disease
☐ Epilepsy/Seizures
☐ Arthritis
☐ Rheumatic Fever
☐ Sinus Problems
☐ Sexually Transmitted Diseases
☐ HIV/AIDS
☐ Kidney Disorder/Dialysis
☐ Liver Problems/Hepatitis
☐ Stomach/Bowel Problems
☐ Glaucoma
☐ Spina Bifida
☐ Stroke
☐ Fainting Spells
☐ Joint Replacement

If you answered yes to any of the above questions, please explain:

____

____

Have you been hospitalized in the past five years? Circle One: Yes or No **If yes, please give date(s) and reason(s) for hospitalization:**

____

____

Family Medical History: ☑ ***if yes for immediate family members (i.e. siblings, parents, grandparents)***

☐ Diabetes
☐ Cancer
☐ Anemia/Blood Disorder
☐ Clotting Disorders
☐ Stroke
☐ Heart Attack
☐ High Blood Pressure
☐ Tuberculosis
☐ Vascular Disease
☐ Heart Problems
☐ Kidney Disorder/Dialysis
☐ Bleeding Disorder/Hemophilia

If you answered yes to any of the above questions, please explain:

____

____

If you answer yes to the following, please list how often:
Do you (patient) use/smoke/chew tobacco? ☐ Yes ☐ No How Often? _______________________
Do you regularly use alcohol? ☐ Yes ☐ No How Often? _______________________
Do you or have you ever used street drugs? ☐ Yes ☐ No How Often? _______________________
Women:
Are you pregnant, planning to become pregnant or nursing? Please explain:

____

Choptank Community Health System, Inc.
Oral Health History Questionnaire

LIST MEDICATIONS YOU (PATIENT) CURRENTLY TAKE: ***(include "as needed" and over-the-counter)***

Name of Medication, Dose, Times Per Day	*Name of Medication, Dose, Times Per Day*

DENTAL HISTORY

Why are you here today? ____

Do you have any previous dental records? _________ Date of last visit to the dentist: _________________

Reason for the last dental visit: ____

Please answer the following questions:

- Do any of your teeth ache? ☐ Yes ☐ No
- Are your teeth sensitive to hot, cold, sweets or pressure? ☐ Yes ☐ No
- Are any of your teeth loose? ☐ Yes ☐ No
- Are there any sores or growths in your mouth? ☐ Yes ☐ No
- Are you wearing a removable dental appliance (dentures/retainer)? ☐ Yes ☐ No
- Have you ever had orthodontic treatment (braces/retainer)? ☐ Yes ☐ No
- Have you ever had a problem after extraction (bleeding/dry socket)? ☐ Yes ☐ No
- Have you ever had abnormal bleeding? ☐ Yes ☐ No
- Have you ever had an allergic/adverse reaction to dental treatment? ☐ Yes ☐ No
- Have you ever fainted in a dental office? ☐ Yes ☐ No
- Have you ever had to take an antibiotic prior to dental treatment? ☐ Yes ☐ No
- Do you have pain and/or clicking in the jaw joint around your ear? ☐ Yes ☐ No
- Do your gums bleed? ☐ Yes ☐ No
- Do you grind your teeth or clench your jaws? ☐ Yes ☐ No
- Do you have any other dental complaints? ☐ Yes ☐ No

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 a change in medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

Patient/Guardian Signature: ____ **Date:** ________________

Provider Signature: ____ **Date:** ________________

Cash Payment Verification for Healthcare Form

Section A: To Be Completed by the Patient

Date: ______________________________

Patient Name: ____

Date of Birth: ____

Name of Employer(s): ____

____ *Printed Name*

____ *Signature*

I understand that I must inform Choptank Community Health System, Inc. (CCHS) of any changes within ten days. By signing this statement, I also understand that any misrepresentation of the information that I provide to CCHS is considered to be a federal fraud punishable by law, including fines and/or imprisonment.

Section B: To Be Complete by the Employer(s)

Date: ______________________________

This is to confirm that ____ is employed at ____. Employment began on ____________________.

S/he currently is paid $____________ per _________________.

If paid hourly, s/he works ___________ hours per week____________.

Employer's Address: ____

Employer's Phone Number: ____

____ *Printed Name*

____ *Signature*

I understand that I must inform Choptank Community Health System, Inc. (CCHS) of any changes within ten days. By signing this statement, I also understand that any misrepresentation of the information that I provide to CCHS is considered to be a federal fraud punishable by law, including fines and/or imprisonment.

NEW DENTAL PATIENT
Dental Location:

Choptank Community Health Systems, Inc.

Sliding Fee Application

Name: ______________________________ Date: ______________________

Mailing Address: ____
P.O. Box or Street Town State Zip Code

Home Phone: ______________ Cell Phone: ______________ Email: ______________

Have you enrolled in this program before? _____ Yes _____ No

_____ Have you completed a Medical Assistance application? Results: ☐ Applied ☐ Pending ☐ Denied

_____ I have Health Insurance through ______________________________

(If you have health insurance, we will bill your insurance carrier and apply the discount to any balance due.)

_____ I have no Health Insurance

HOUSEHOLD INCOME

Please list ALL MEMBERS of your household (including yourself). Include those who contribute to the household income and all persons for whom you are financially responsible or those you can claim on your taxes.

Name	Birth Date	Relationship to Applicant	Type of Income (from below)

TYPE OF INCOME STATUS DOCUMENTATION REQUIRED

***Written verification for each source of income is required within 30 days in order to process your sliding fee application. Without verification, your account will not be discounted; $95 deposit is expected prior to receiving services. Income verification must include GROSS INCOME. Acceptable forms of written income verification include:**

EMPLOYED
Prior year Federal tax return
Weekly – Four consecutive pay stubs
Bi-Weekly – Two consecutive pay stubs

SELF EMPLOYED
Form 1040 (not Schedule C)– Most recent
Federal Business And personal tax returns
Cash Payment Verification for Healthcare Form

UNEMPLOYED
Unemployment Claim determination letter

RETIREMENT
Social Security award letter (current year) and pension Documentation (if applicable).

CHILD SUPPORT/ALIMONY
Legal documents showing amounts received for support and/or alimony

DISABILITY
Social Security award letter (current year)

OTHER
Any other form of income not stated above

NO INCOME IS RECEIVED*
No income is received from any source- -Zero Income Form

RESPONSIBILITIES AND TERMS OF SERVICE

I certify that all information is true and complete to the best of my knowledge. I understand that any false information of family size and/or financial information may result in loss of eligibility for all household members. I fully understand that I am responsible for medical, dental and/or laboratory services until written verification of income is provided for each household member listed above.

______________________________ ______________

Applicant Signature Date

☐ Application Declined

Choptank Community Health System, Inc.
Sliding Fee Scale Program Patient Agreement

I agree that the following has been explained to me and that I will follow ALL the guidelines of this program. I understand that:

1. Only services that are medically necessary and ordered by staff of CCHS are covered under this program.

2. Employment, school and sports physicals are not covered under this program if the fees are paid by the employer, school or team.

3. Some in-office procedures may not be covered by this program. If the service is not covered, will assist you with payment arrangements.

4. Only laboratory services that are performed in our office are covered under this program. Pending sliding fee applications do not qualify for labs; and pathology is not covered under the SFS program.

5. This program has limited coverage for radiology services. This program does not pay for inpatient or emergency room services of any kind.

6. The effective date of my participation in this program is decided by CCHS. Your enrollment is generally good for one year.

7. I agree to notify CCHS if my income level or number of people in my household changes before it is time for renewal of my/our participation in the program.

8. I understand that I am required to bring documentation for proof of income for the persons listed on my application. I understand that the staff of CCHS may request verification of income at any time during my/our participation in the program.

9. All income is subject to verification.

10. I understand that I may be referred to one of CCHS's Community Support Specialists (CSS) for evaluation and assistance. I also understand that by submitting an In-Kind Statement as proof of income, I will be required to meet with a CSS within 30 days of submitting the application. Failure to meet with a CSS may result in termination of the sliding fee discount.

11. Payment of sliding fee scale fees is required at the time the service is received.

Signature____ Date___________________________

Print Name: _______________________________________ Date of Birth: __________________________