**New Patient Enrollment Packet for Clyburn Community Health Express Rural Health Services Mobile Dental and Medical Unit – Adults**

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Dear Patient:

The Clyburn Community Health Express Mobile Dental and Medical Program are coming to your location soon. Dental and medical care will be provided in conjunction with **Rural Health Services Dental and Medical Departments located at** 1000 Clyburn Place, Aiken, SC 29801.

If there are services not covered in full by your insurance or Medicaid, you also have the opportunity to apply for a discount on any remaining balances through our Sliding Fee Scale. If your insurance changes, make sure we get an updated copy of your insurance card and/or updated insurance information. If you do not have dental or health insurance, staff at Rural Health Services can help you enroll in other optional programs including Medicaid, Marketplace Plans (when available), or our Sliding Fee Scale.

**If you would like the opportunity to see the dental or medical team, please complete the information.** The information can only be filled out by you and must be filled out in **ink.** If you have any questions about this program please call RHS at **(803 845-9158)**

**Dental and Medical**

INFORMED SIGNED CONSENT: Informed consent indicates your awareness of sufficient information to allow you to make an informed personal choice concerning your dental and/or medical treatment. Mobile unit dental appointments will include: exam, x-rays, extractions, and fillings. If further treatment is required, a treatment plan will be explained to you. Treatment plans and consents must be signed as a soon as possible to allow for continuous treatment. Some patient treatment may be deemed too difficult for completion on the mobile unit. These cases will be scheduled with RHS Dental and/or Medical staff for completion.

Mobile unit medical appointments will be for flu shots, urgent care, exams and treatment. If further treatment is required, recommendations for treatment will be discussed with you. In most cases, you will need to visit the nearest Rural Health Center for further treatment

**First and Last Name: Date of Birth:**

**Social Security Number: Address: City: State: Zip: Phone #: Phone #:**

**Gender (circle one):** Male

Female

Transgender

**Race (circle):** American Indian

Alaskan Native

Asian

Black/ African American Native Hawaiian

White

Other Pacific Islander Multiple Races Hispanic/Latino Not Hispanic/Latino Other Unreported/Refuse to Report

**Language (circle):** English, French, German, Italian, Japanese, Spanish, Portuguese, Sign Language, Other

**Housing (circle):** Single Family Home, Multiple Family Home, Homeless, Transitional Housing (shelter), other, and Decline to answer

**When was your last visit to a dentist or doctor? Dentist: Doctor: Choice of Pharmacy:**

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| **Responsible Party****Responsible Party: Refers to the carrier of the insurance (may be a spouse or parent) and/or the person responsible for payment.** The responsible party is financially responsible for payments in full for all accounts. I understand that my dental or medical insurance carrier or payer of my benefits may pay less than the actual bill for services.Responsible parties will be billed for any services not covered, or exhausted benefitsName: SS#:\_ Address (street, city, and zip): Home Phone Number: Cell Phone Number:  |  |
|  | **Any person that you would give permission to sign consent or agree to treatment for you, if so this also allows the medical and dental team to discuss any necessary information pertaining to your care. Please List below (optional):****First and Last****Name: Relationship****Phone:**  |
|  |

**Address:**

Medicaid Provider Medicaid #\_

**Insurance Information**

**Circle One:** No Insurance

**Dental Insurance**

Medicaid Private Insurance Separate Medical and Dental Insurances

Name of Insurance Company:

Policy Holder’s Name: SS#: Policy Holder’s s Address (including city, state &zip):\_

Group Number: Employer: Phone #: ID Number

**Medical Insurance**

Name of Insurance Company: Policy Holder’s Name:

Policy Holder’s Address (including city, state and zip):\_ Group Number: Employer: Phone #: ID Number:

**Family Yearly Income: $ (or circle :)** Decline to Answer

**Medical History: Do you have a history of any of the following? Write YES or NO on the line beside the question.**

Have you had any surgery in the past? If yes, please explain: Are teeth causing pain? Do you smoke? Are you pregnant or possibly pregnant? Has there been any change in your health in the past year? Are you taking medications including inhalers? If so, please list: Have you ever been hospitalized overnight? If so, please list dates and reason. Do you have any allergies (food, medication, anesthetics, latex, etc?) Do you have a history of cancer or malignancy? If yes, please provide the date of last Chemotherapy,

Radiation treatment or other cancer treatment\_ Do you have artificial joints (knee, hip, shoulder, etc.)? If yes, what date was it placed and is there any complications?

Have you been in contact with the AIDS virus or have they been tested positive for HIV? Do you use tobacco products and/or recreational drugs? If yes, please list type\_

Do you have any known heart conditions? If yes, what condition:

Do you have any other medical problems not already listed? If yes, please explain

**If you have a history of any of the conditions listed below write S for self on the line. If a family member has a history of any of the conditions listed below write an F on the line. If there is no history of a condition, Write NO.**

 **High or low Blood Pressure**

 **Ulcer or Acid Reflux**

 **Heart Transplant**

 **Pacemaker**

 **Blood Transfusion**

 **Bacterial Endocarditis**

 **Cortisone Steroid Treatment**

 **Stroke or mini-stroke**

 **Congenital Heart Disease (Heart defects noted from birth**

 **Anemia (including sickle cell anemia) Type:**

 **Artificial or prosthetic heart valve, stent, or graph**

 **Epilepsy and/or Seizure**

 **Arthritis**

 **Sinus Problems (hay fever)**

 **Sexually Transmitted infection (Disease). XPLAIN: \_**

**Medicaid Provider**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Medicaid #**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Breathing Problems or lung disorder? EXPLAIN:**

 **Kidney Trouble, EXPLAIN: \_**

 **Tuberculosis, MRSA, or any other infectious disease. EXPLAIN:**

 **Asthma- List Triggers and date of last attack**

 **Liver disease, Hepatitis, jaundice, bleeding disorder or history of Leukemia, EXPLAIN: \_**

 **Nervous Disorder or Behavioral problems EXPLAIN: \_**

# Authorization

1. I authorize the dental staff to perform diagnostic procedures and treatment as may be necessary for proper dental care, including (but not limited to) exams, x-rays, extractions and fillings.
2. I authorize the medical staff to perform urgent care, exams, medical assessment, flu shots, and treatment.
3. I authorize the RHS medical staff to immunize if needed.
4. I authorize the RHS mobile unit medical staff to administer a flu shot if needed.
5. I authorize the dentist to perform further treatment as indicated on the treatment plan
6. I authorize the release of any information concerning my health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
7. I authorize the release of any information of my healthcare, advice, and treatment to another dentist, doctor, or other authorized individual.
8. I hereby authorize payment of insurance benefits directly to Rural Health Services, otherwise payable to me.
9. I understand that my dental or medical insurance carrier or payer of my dental or medical benefits may pay less than the actual bill of services. I understand that I am financially responsible for payments in full for all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or part, by my dental care payer.
10. I attest to the accuracy of the information contained within this packet. I understand that it is my responsibility to inform the doctor and staff of any changes in my medical status at the very next appointment before any treatment is rendered.

Signature of Patient Relationship to Patient Date

**Acknowledgment of Receipt of Notice of Privacy Practices and Authorization of PHI Disclosure**

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights can be found at [www.HHS.gov](http://www.hhs.gov/) by returning this form to your child's school; I acknowledge my understanding of my rights in regard to HIPAA. I also am aware that treatment plans that may contain health information may be sent home with my child for my review.

I understand that I may revoke this authorization at any time by contacting RHS at the contact information listed above.

# Signature Date