Adult Dental Clinic New Patient Packet

Our non-profit clinic provides free dental care to qualifying residents of Fairfield, Lexington, Richland and Sumter counties. Our goal is to provide quality care to as many patients as possible, therefore we ask for your help to make your time spent with us productive.

ARRIVE PREPARED:

- Read the attached packet for eligibility
- Collect documentation of your proof to qualify
- Complete New Patient Packet prior to your arrival
- Complete Health History with accurate Information

ARRIVE ON TIME:

Appointments are available for treatment with the dentist.

REMAIN AT THE CLINIC:

Be prepared to stay in the clinic for several hours. Take your medication as prescribed by your physician and have a nourishing meal prior to arrival. All patients are asked to remain in the clinic until their treatment is complete. The doctor will see you as soon as possible.

For their safety, do not bring children to the clinic.

WellPartners Adult Dental Clinic	**WellPartners Adult Dental Clinic**
Richland County Health Department2000 Hampton Street, Suite 3145Columbia, SC 29204Phone: 803.888.1690Hours: Monday—Thursday 8:30 A.M.—5:00 P.M.Friday 8:30 A.M.—12:00 P.M.	Lexington County Health Department Red Bank Crossing 1070 South Lake Drive, Suite B Lexington SC 29073 Phone: 803.785.6653 Hours: Monday 8:30 A.M.—5:00 P.M. Tuesday 12:30 P.M.—4:00 P.M. Thursday 12:30 P.M. —5:00 P.M.

ADULT DENTAL CLINIC

SCREENING CHECKLIST FOR ELIGIBILITY

To meet eligibility, you must provide the clinic with following items at your FIRST VISIT:

1. **ADULT REFERRAL PACKET:**
   - **completely and accurately filled out and signed**
2. **SOUTH CAROLINA PHOTO IDENTIFICATION:**
   - **Valid SC ID or driver's license**
3. **DOCUMENTATION TO VERIFY PATIENT ELIGIBILITY:**
   - **18 years or older** (your license or ID)
   - **A resident of Fairfield, Lexington, Richland or Sumter County** (your license or ID)
   - **Low income** (≤ 200% of poverty level)
   - **No dental insurance**

YOU MUST PRESENT AT LEAST ONE TO VERIFY LOW INCOME AND NO DENTAL INSURANCE: The following are examples of acceptable documentation to verify your eligibility.

- **Check stub(s) for patient seeking treatment**
- **W-2 form**
- **Medicaid card or verification of SNAP benefits (EBT card)**
- **Verification of Social Security income, SSI Disability, VA pension or retirement income**
- **If you do not work but live in the household with someone that receives any of the above, their income must be verified with above.**
- **If you live in a household and someone else pays your expenses, you must provide a written statement: specify the amount paid monthly, signed by both you and the person paying expenses.**

ADULT DENTAL CLINIC

REGISTRATION AND HEALTH HISTORY

PERSONAL INFORMATION: **Date: ___________________________**

Name:	**Home Address:**	**Work Address:**	**SC Driver's License:** Yes or No
______________________________ ______________________________	______________________________ ______________________________ ______________________________ **Phone #:** ____________________	______________________________ ______________________________ ______________________________ **Phone #:** ________________	**#:** **SC Identification: Yes or No** **#:**
Social Security #: ______________________________	**Date of Birth:** ____________________	**Occupation:** ______________________________ ______________________________	**Medicaid: Yes or No** **#:** **Medical/Dental Insurance: Yes or No**
Education: circle one Elementary High School College Masters/Doctorate	**Race: circle one** Asian Black Hispanic/Latino Native American White Other	**Sex: circle one** Male Female **Marital Status: circle one** Single Married Widowed Divorced	**Your Physician:** **Name and Address or Phone #:** ______________________________ ______________________________ ______________________________ ______________________________ **Date of last visit:** ________________ **Treated for:** ____________________ ______________________________ ______________________________ **Date of last physical:** ______________ **Your Height:** ________________ **Your Weight:** ________________
EMERGENCY Contact: Name: ______________________ Phone #: ____________________	**Closest Relative:** Name: __________________________ Phone #: ________________________	**Name of last Dentist:** ______________________________ **Date of last visit:** __________ **Treated for:** ________________ ______________________________ ______________________________ ______________________________	**Have you used the emergency room for dental problems:** **Date of last visit:** ________________ **Treated:** ______________________ ______________________________

MEDICAL INFORMATION

LIST YOUR <u>CURRENT MEDICATIONS</u> HERE (or give written list to clinical staff): ________________________

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PLEASE TAKE YOUR PRESCRIBED MEDICATIONS AS DIRECTED PRIOR TO COMING TO CLINIC

CHECK BOXES **ANSWER ALL QUESTIONS THAT APPLY.**

YES	NO	
		Are you taking any medications?
		Are you **allergic** to any medications?
		Have you been seriously ill in the last **five** years?
		Have you ever been hospitalized or had a serious illness?
		Have you been informed by a physician that you need to be pre-medicated for dental treatment? Circle reason: **Artificial Heart Valve** **Artificial Joint** Other:_________________
		Do you have a persistent cough?
		Have you resided or worked with anyone who has had tuberculosis?
YES	NO	↓ **QUESTIONS BELOW FOR WOMEN** ↓
		Are you pregnant? If so, what month?
		Are you taking birth control pills?
		Are you in or have you been through menopause?
		Are you or have you taken medication for osteoporosis?

Name____ Date__________________

CHECK BOXES **DO YOU <u>HAVE, OR EVER HAD</u>, ANY OF THE FOLLOWING <u>CONDITIONS</u>?**

YES	NO		YES	NO	
		AIDS/HIV positive			Heart Trouble or Murmur
		Allergies: list_______________________ ____________________________________ ____________________________________			Heart Attack: date_________________
		Anemia: type_______________________ ____________________________________			Hepatitis: type____________________ Date______________________________
		Arthritis/Rheumatism			High Blood Pressure (hypertension) Low Blood Pressure (hypotension)
		Bleeding Disorders			Hives or Skin Rash
		Blood Disease			Kidney Disease
		Blood Transfusion			Liver Disease
		Cancer or Tumor: type—			Osteoporosis Joint Replacement: date_____________
		Chemotherapy/Radiation: date—			Psychological Problems

		Chest Pains (angina)			Rheumatic Fever/Rheumatoid Heart Disease
		Contact Lenses			Sinus Trouble
		Cortisone/Steroid treatment			Shortness of Breath
		Diabetes (sugar disease): circle type type 1 (insulin) type 2 (diet controlled)			Heart Valve, Heart Stent, Pacemaker Date—
		Drug/Alcohol addiction			Stomach/Intestinal Disease (ulcers)
		Drug Reaction			Stroke
		Epilepsy (seizures) or Paralysis: Type—			Swelling of hands or feet
		Eating Disorder: Type—			Thyroid Disease
		Fainting (frequent)			Tuberculosis (TB)
		Headaches (frequent)			Lung Disease - Emphysema
		Head Injury: date –			Venereal Disease

IN THE PAST TWO YEARS, HAVE YOU TAKEN ANY OF THE FOLLOWING MEDICATIONS?

YES	NO		YES	NO	
		Antibiotics (Penicillin, Zithromax Z-pak, INH, Rifampin, Tetracycline, etc.)			Insulin (diabetes medication)
		Anticoagulants (blood thinners: Coumadin, Plavix, etc.)			High blood pressure medication: List—
		Pain or anti-inflammatory medication (Cortisone steroid injections, Prednisone)			Heart medication (Digitalis, Nitroglycerin, etc.) List—
		Non-steroid drugs (Aspirin, Ibuprofen, Advil, etc.)			Osteoporosis medication (Fosamax, Boniva, Hormone replacement meds.)
		Antihistamines (Benadryl, etc.)			Tranquilizers or sleep aids: list—
		Sulfa Drugs			

Other condition(s) the doctor should be aware of prior to your care:

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Name____ Date_____________________

CHECK BOXES **ARE YOU ALLERGIC TO, OR HAD AN ADVERSE REACTION TO, ANY OF THE FOLLOWING:**

YES	NO		YES	NO	
		Antibiotics (penicillin, tetracycline, etc.)			Sulfa drugs
		Barbiturates (sleeping pills, sedatives, etc.)			Local anesthetics
		Iodine			Latex
		Narcotics (codeine, etc.)			Other:

DENTAL INFORMATION

CHECK BOXES **DO YOU HAVE, OR EVER HAD, ANY OF THE FOLLOWING DENTAL CONDITIONS?**

YES	NO		YES	NO	
		Severe dental pain			Do you brush your teeth less than twice a day?
		Fear of the dentist or dental treatment			Do you floss your teeth less than once a day?
		Grinding or frequent clenching of teeth			Have you ever been told you have gum disease?
		Pain when opening or closing mouth			Have you ever had periodontal (gum) surgery?
		Unpleasant taste or order in your mouth			Date of last dental cleaning:
		Bleeding gums when brushing/flossing			Have you noticed any shifting teeth?
		Swelling			Have you ever worn braces?
		Prolonged bleeding after tooth extraction?			Do you have sensitivity to hot, cold, or sweets?
		Adverse (bad) reaction to dental anesthesia (Novocain)			Have you noticed any discoloration or unusual conditions of your teeth, gums, or mouth tissue?
		Tobacco Use - MAY LEAD TO DENTAL CONDITIONS: Smoke? # of packs_________________ Chew? ______________________ Frequency____________________			Other:_____________________________ ___________________________________ ____________________________________

Signature____ **Date:** ___________

STAFF ONLY: Health History Update

ADULT DENTAL CLINICS

POLICIES AND PROCEDURES

***Adult patients are defined as 18 years or older.**

***No children are allowed in the clinic during adult clinic hours.**

***Adult patients must bring eligibility documentation as previously described in Screening Checklist.**

***Patients must live in Fairfield, Lexington, Richland or Sumter County and seek treatment at the clinic in which they reside.**

Lexington County Residents	Fairfield, Richland and Sumter County Residents
Location: WellPartners Lexington County Health Department Red Bank Crossing 1070 South Lake Drive, Suite B Lexington, SC 29073 Phone: 803.785.6653	Location: WellPartners Richland County Health Department 2000 Hampton Street, Suite 3145 Columbia, SC 29204 Phone: 803.888.1690
Parking: Free	Parking: Public metered parking; bring change for the meter
Clinic Hours: Monday: 8:30 A.M. – 5:00 P.M. Tuesday: 12:30 P.M. – 4:00 P.M. Thursday: 12:30 P.M. – 5:00 P.M.	Clinic Hours: Monday –Thursday: 8:30 A.M. – 5:00 P.M. Friday: 8:30 A.M. – 12:00 P.M.
Please, plan to be here several hours. The doctor will see you as soon as possible.	
Clinic Closures: The clinics observe all county holidays when the building is closed. Notice will be posted for other closures.	

ADULT DENTAL CLINICS

POLICIES AND PROCEDURES continued

Our Dental Clinic is designed primarily for **basic** preventive treatment, restorative treatment, and emergency care. These services will be provided as long as funding is available. **Dental Emergencies** are defined as **oral pain, infection, or trauma.**

Procedures Provided:
Eligibility/Emergency Exam and Screening
Radiographs (x-rays)
Basic dental cleaning (once a year)
Basic restorative treatment (fillings)
Simple & Uncomplicated Surgical Extractions

Procedures Not Provided:
Root Canals
Crowns/Bridges
Dentures/Partials
Complicated Surgical Extractions
(Wisdom Teeth, Impacted Teeth or Roots)

No Sedation:
Nitrous oxide, known as "laughing gas" is not available in any of our Dental Clinics

No Comprehensive Exams:
Due to limited time and resources, detailed dental examinations are not available for: medical procedures dental clearance for surgery military dental clearance comprehensive periodontal examinations

Dentist reserves the right to refuse or postpone treatment:
Patient is disruptive or under the influence (alcohol or drugs of any kind).
Patient has a complicated or high risk medical history requiring treatment in an acute Care facility (hospital or an oral surgeon).
Patient has infection which may prevent proper anesthesia.
Patient has a complicated procedure which requires specialist.

I have read or someone has read the policies of this program to me. I understand the policies and procedures and give permission for myself to be treated by the dentist and /or hygienist employed by the Community Partners of the Midlands, LLC, WellPartners Adult Dental Clinics.

Signature/Mark of Patient Date

Adult Dental Clinic	
WellPartners Adult & Children's Dental Clinics Lexington County Health Department Red Bank Crossing 1070 South Lake Dr., Suite B Lexington, SC 29073	WellPartners Adult Dental Clinic Richland County Health Department 2000 Hampton Street, Suite 3145 Columbia, SC 29204

ACKNOWLEDGEMENT OF RECEIPT -- NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement.

I, ____ have read, and/or
(Your Name) **requested a copy of the office's Notice of Privacy Practices.**

____
Print your name

____
Signature

____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgement could not be obtained because:

- ☐ **Individual refused to sign.**
- ☐ **Communication barriers prohibited obtaining the acknowledgement.**
- ☐ **An emergency situation prevented us from obtaining acknowledgement.**
- ☐ **Other, please specify:**

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Turn page to read Notice of Privacy Practices →

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY. THE PRIVACY OF YOUR HEALTH IS IMPORTANT TO US.

OUR LEGAL DUTY: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice is now in effect and will remain so until we replace it. We reserve the right to change our privacy practices, and the terms of the Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we well change the Notice and made the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices or for additional copies of this Notice, please contact us using the information above.

USES AND DISCOSURES OF HEALTH INFORMATION: We use and disclose health information about you for treatment, payment, and healthcare operations. For example—

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: Currently, the Programs provide services free of charge. We may use and disclose your health information to obtain payment for services we provide you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualification of healthcare professions, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information, or to disclose it to anyone for use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in the Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patients' Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosure. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences toward your best interest in allowing person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of healthy information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert serious threat to your health or safety, or the health or safety of others.