AppHealthCare
Caring for our Community

AppHealthCare

Appalachian District Health Department
www.AppHealthCare.com

Caring for our Community

NORTH CAROLINA Local Health Department Accreditation Board
Accredited Health Department
2017-2021

Dear Parent/Guardian,

AppHealthCare is working with the school system to provide dental health services to students who do not currently have a dentist. Dental health care is an important part of overall health and we are determined to help your child have a healthy smile for life. AppHealthCare is a local health department and federally qualified health center (FQHC) that provides dental services on-site at schools using portable equipment and health department staff.. We encourage your child to receive dental care, and we would appreciate the opportunity to care for your child.

As a local health department and FQHC, we are required to collect information on the patients we serve. This information helps us to serve our patients better. This information will be kept confidential and will not be shared or sold. If you are interested in your child receiving dental services, we would appreciate your attention to the forms included with this letter and complete them in their entirety so we can best serve your child. These forms will be kept current and on file for the FY 20-21 school year.

If you have any questions, please reach out to us.

Thank you,

AppHealthCare Dental Health Services Team
Phone: (336) 246-9449 ext: 2131
www.AppHealthCare.com

BUSINESS OFFICE	ALLEGHANY CO. HEALTH CENTER	ASHE CO. HEALTH CENTER	WATAUGA CO. HEALTH CENTER
157 Health Services Road	157 Health Services Road	413 McConnell Street	126 Poplar Grove Connector
PO Box 309	PO Box 309	PO Box 208	PO Box 307
Sparta, NC 28675	Sparta, NC 28675	Jefferson, NC 28640	Boone, NC 28607
336-372-5641	336-372-5641	336-246-9449	828-264-4995
336-372-7793 Fax	336-372-7793 Fax	336-246-8163 Fax	828-264-4997 Fax

Revised 5/27/2020

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Dental Health Consent Form

NORTH CAROLINA Local Health Department Accreditation Board
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AppHealthCare is pleased to be able to provide preventive care at your child's schc ol. Thank you for your interest in our Portable Dental Program. Our program provides the following servi es for students via licensed dental professionals during school hours:

- Comprehensive Exams
- Limited Exams
- Tele-Dentistry Exams
- Dental Cleanings
- Dental Sealants
- Fluoride Application
- Dental Screenings
- Oral Hygiene Instruction
- Nutritional Counseling
- Radiographs (X-Rays)

Please note this dental program is available for all children who do NOT have a regul ır dentist. PLEASE FILL OUT THE BOX BELOW REGARDLESS OF YOUR CHILD'S PARTICIPATION IN THE PROGRAM A ND RETURN IT TO THE SCHOOL NURSE.

Student Name: _____ **Grade:** _____ **DOB:** ___ _____

Teacher: _____ **School:** _____ _____

☐ **NO. I DO NOT give permission for my child to participate in the school dental p ɔgram.**

☐ **YES. I have read this form and give permission for my child to *FULLY PARTICIPA E* in the school dental program, including tele dentistry visits. (Complete remainder of this form prior o returning to your child's school nurse.)**

☐ **YES. I have read this form and give permission for my child to have a *DENTAL S REENING ONLY*. (Complete patient registration only and return to school nurse.) Child will be ev ıluated for any oral conditions (including decay and bite). No treatment will be rendered at this tin e.**

Parent Signature: _____ **Date:** _____ _____

I voluntarily consent to routine dental treatment by AppHealthCare for the above named m ıor for whom I am parent or guardian. I understand that specific and separate consents will be requested from me prior :o any non-routine, hazardous, or major treatment. I request payment of authorized Medicare, Medicaid, and c her third party payers' benefits on my behalf for any services furnished me by this agency. I authorize AppHealthC ıre to release information needed to determine benefits for this service. I understand I will be responsible for charges ot covered by my insurance, as applicable. I understand that I may pay my charges using check, cash, credit card, or debit ard. I authorize the release of information to the extent necessary to carry out the following purposes: fiscal and accountir ;, or consultation and referral. I certify the financial information I have given is correct and give my permission for AppHealt Care to contact my employer or any other agency for verification, if necessary. I understand I should notify AppHealthCare f my income or other information changes. I also understand that payment plans are available for any balance due ınd that I may choose to have a payment plan by contacting AppHealthCare if I am unable to pay the full balance due. Appl ealthCare participates in the NC Debt Set-off Program as authorized by the Set-off Debt Collection Act (N.C.G.S. 150A 18C· .34). Any unpaid account balance of $50.00 or more that is more than 90 days past due may be withheld from your ir ome tax refund or lottery winnings. Patients who have verified their income as part of the Sliding Fee Scale discount p ogram and are determined to be at or below 100% of the Federal Poverty Level will not be subject to these collections. By signing above, I hereby acknowledge that I have access to a copy of the "Notice of Privacy Practices" (upon request for AppHealthCare and understand that I may contact the HIPAA Privacy Officer if I have questions about the conte t of the notice.

Revised 5/27/2020

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Grade: _____ **Teacher:** _____ **School:** _____

Patient Registration

First Name_____Middle Name_____Last Name_____
Preferred Name_____ Date of Birth_____ Gender: M / F
Address_____City_____State_____Zip_____
Preferred Contact Method (Circle one): Home Phone / Work Phone / Cell Phone /Email
Parent Name_____
Home Phone_____Work Phone_____Cell Phone_____

Race (Circle ONE)
White
Black-African American
Asian
Native Hawaiian
Pacific Islander
Multi-racial
Unknown/Declined/Other
American Indian/ Alaska Native

Ethnicity (Circle ONE)
Hispanic-Latino
Not Hispanic-Latino
Decline to Answer

Preferred Language (Circle or Note)
English
Spanish /Other_____
Country of Origin_____

Housing (Circle ONE)
Rent/Own
Emergency Shelter
Street (staying in vehicle, park, abandoned building)
Temporary Community Housing/Halfway House
Pending Independent Living (transitional)
Doubling Up (Living with family/friends)
Other: _____

Health Care Information (This information is used to send visit information to your primary care provider.)
Your Doctor's Name_____Phone_____
Your Dentist's Name_____Phone_____
If none, would you like AppHealthCare to be your child's dentist/doctor? _____Yes _____No

Patient health history: Please check any conditions or health concerns your child has or has had in the past:

- ☐ NONE
- ☐ ADD/ADHD
- ☐ Anemia
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Blood Disease / Sickle Cell
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Diabetes
- ☐ Down's Syndrome
- ☐ Epilepsy
- ☐ Fear of the dentist
- ☐ Head Injury
- ☐ Hearing Loss
- ☐ Heart Trouble
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV / AIDS
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mumps
- ☐ Nervous Disorders
- ☐ Pink Eye/Conjunctivitis
- ☐ Pregnancy (NOW)
- ☐ Respiratory Problems
- ☐ Low Blood Pressure
- ☐ Rheumatic Fever
- ☐ Seasonal Allergies
- ☐ Seizures
- ☐ Sexually Transmitted Disease
- ☐ Teeth Grinding
- ☐ TMJ
- ☐ Thyroid Problems
- ☐ Tobacco Use / Smoking
- ☐ Ulcers

Do you have any concerns about your child's dental health?_____

Does your child have allergies to any of the following? (Check all that apply)

- ☐ Latex products
- ☐ Anesthesia
- ☐ Penicillin
- ☐ Codeine
- ☐ Other allergies (please list) _____

Does your child have any other serious illness (es) that are not listed above? If yes, please describe.

_____

Please list all medications and dosages your child is currently taking.

_____

_____

Emergency Contact:_____ Phone:_____ Relationship:_____

Parent/Guardian Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

Revised 5/27/2020

Student Name: _____ **Grade:** _____ **DOB:** _____

Teacher: _____ **School:** _____

Dental Insurance & Income Informatio

Insurance Info (Circle ALL that apply):

Medicaid:
- Full NC Medicaid
- Family Planning Waiver Only
- BCCCP Only
- HEALTH CHOICE

Medicare:
- Red, White & Blue Card
- Medicare Advantage (replacement Plan thru United, BCBS, etc.)

O her Commercial:
- Blue Cross
- United Healthcare
- Other-Specify_____

U -Insured/Self-Pay

W rker's Compensation

Insurance Name (Primary Policy)_____ Policy Number_ _____

Group_____ (Policy & Group # not required if card is provid d)

Policy Holder's Name/relationship_____

Policy Holder's Date of Birth_____

Effective Date of Insurance_____

Insurance Name (Secondary Policy)_____

Policy Number_____

Group_____ _____

(Policy & Group # not re uired if card is provided)

Policy Holder's Name/re itionship_____

Policy Holder's Date of B th_____

Effective Date of Insurar e_____

Please Complete Household Information below as you may be eligible for a Sliding Fee Sca e Discount. Proof of income must be provided within 10 days of date of service to avoid fees being charged at full price and patient receiving a bill. **AppHealthCare sliding fee discounts will not apply to outside services, if you are referred to nother provider or agency for additional care.**

Household Members	Relationship	Employed? Yes or No	Employer	Annu al Income	(For Office Use) Date Verified
SELF	SELF				

We understand that some insured patients may prefer to not disclose individual income da a. **By not disclosing family income, however, you are acknowledging that you understand that we will not be able to pr vide the Sliding Fee Scale discounts that you may be eligible for, which may offer significant savings.** Indicate by circlin if you still:

PREFER NOT TO ANSWER

Please note: AppHealthCare participates in the NC Debt Set-off program as a means to colle t unpaid charges. If you accrue unpaid debts they may be deducted from your NC State Tax Refund. If patient is a ch ld please complete for parent/caregiver information below:

Father's Name_____ DOB_____ Phone___ _____

Email_____ SS#_____-_____-_____

Mother's Name_____ DOB_____ Phone___ _____

Email_____ SS#_____-_____-_____

Parent/Guardian Signature: _____ **Date:** __ _____

Witness Signature: _____ **Date:** __ _____