Georgia Department of Public Health
District 4 Public Health

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Uninsured Patient Dental Program

Application Packet

This program is available for the uninsured patient with an income of less than 200% of the current Federal Poverty Level.

Dental Services available:
*** dental exam *x-rays *cleanings *fillings *extractions *sealants**

After completing an application packet, we will schedule an initial appointment. You may submit the application packet to the Health Department or to the Dental Clinic.

To participate in the Uninsured Patient program, proof of income must be provided along with a photo ID.

If you have no income, then proof of support must be provided. If you are supported by someone other than your spouse, that person must personally come into the Health Department or Dental Clinic, provide a photo ID and proof of income, and write a brief statement that they are supporting you. This statement and information will then become a permanent part of your record.

The first visit will consist of an exam by the dentist and any necessary x-rays needed to discuss treatment options. **Any treatment that can be accomplished at our clinic will be scheduled for a future appointment.**

Many preventative services are scheduled with a dental hygienist under general supervision without the dentist being present. Dental examinations and updated x-rays are recommended every six months but required at a minimum interval of every 12 months.

Patients with treatment needs that are more extensive than we provide here will be referred out to other dental providers or specialists. **There is a charge for the initial exam and x-rays, even if a referral for treatment is needed.**

Payment is expected PRIOR to receiving any services. Cash, debit or credit card payment accepted at this time.

My signature below indicates that I understand and agree with the office policies outlined above.

_____ _____

Signature Date

Georgia Department of Public Health

District Four Health Services
Heard & Lamar County Dental Clinic

For Office Use Only

Medical Alert:_____
I have reviewed this Medical History:
_____ **Name** _____**Date**

Name: Last First Middle			**Birth Date:**
Home Phone: ( )_____ **Cell Phone: ( )**_____ **Work Phone: ( )**_____	**Sex:** M ☐ F ☐	**Age:**	**Social Security #** ☐☐☐-☐☐-☐☐☐☐
Race: Black ☐ **White** ☐ **Multiracial** ☐ **Asian** ☐ **Hispanic/Black** ☐ **Hispanic/White** ☐ **Amer.Indian/Alaskan** ☐ **Unknown** ☐			
Address: Street City Zip		**County**:	**Are you married?** ☐ **Yes** ☐ **No**
Parent/Guardian Name or Emergency Contact			**ER Contact Phone:**
Has the patient ever been to the dentist?	**Yes** ☐ **No** ☐	**Date of patient's last dental visit?**	
☐ **Medicaid** or **PeachCare** ☐ **Amerigroup** ☐ **PeachState** ☐ **WellCare** ☐ **CareSource**	**Member Number:**		

DOES PATIENT HAVE or HAS PATIENT EVER HAD:

Yes	No		Yes	No	
☐	☐	**High Blood Pressure**	☐	☐	**Stroke**
☐	☐	**Cancer**	☐	☐	**Dental Anxiety or Fear**
☐	☐	**Asthma**	☐	☐	**Kidney Disease**
☐	☐	**Tuberculosis**	☐	☐	**Liver Disease**
☐	☐	**Diabetes**	☐	☐	**Thyroid Disease**
☐	☐	**Hepatitis**	☐	☐	**HIV or AIDS**
☐	☐	**Heart Murmur or Heart Condition**	☐	☐	**Rheumatic Fever**
☐	☐	**Epilepsy or Seizures**	☐	☐	**S. T. D.**
☐	☐	**Psychiatric Problems**	☐	☐	**Special Needs**
☐	☐	**Do you use tobacco?**	☐	☐	**Do you require antibiotics prior to dental treatment? If so why?** _____
☐	☐	**Blood Disease (Anemia, Sickle Cell Disease)**			
☐	☐	**Are you pregnant or think you may be?** ____**Number of weeks**	☐	☐	**Any complications?**
☐	☐	**Other Allergies or Drug Allergy? (Explain)**			
☐	☐	**Is patient under the care of a Physician for any <u>medical condition</u>? (Explain)**			
☐	☐	**Other severe illnesses, hospitalizations, or any condition not listed on this form? (Explain)**			
☐	☐	**Is patient taking ANY medication? <u>LIST ALL</u> Prescriptions and Over-the-counter:**			

CONSENT: I consent to dental treatment for myself or my minor child, which in the judgment of the medical or dental staff is necessary for oral health. This treatment may include but is not limited to the following: examination of teeth, sealant placement, prophylaxis (cleaning), scaling, fluoride application, restoration of teeth, extraction of teeth, x-rays, administration of drugs/local anesthetic, and/or other specialty treatments deemed necessary. Many preventative services are scheduled with a dental hygienist under general supervision without the licensed dentist being present. I approve the release of my records to my insurance provider or other health care professionals as deemed necessary by the medical or dental staff. I authorize District Four Health Services to file claims and receive reimbursement directly from my insurance provider. I understand that this request for dental treatment is valid for as many years as I or my child is eligible for this service. I further **verify that the above medical history is true and accurate to the best of my knowledge** and I have received the District Four Health Services **NOTICE OF PRIVACY POLICY**. This permission can be revoked only by written notification to the Dental Program Administrator, District Four Health Services, 301 Main Street, LaGrange, Ga.

Signature _____**Date**_____

***** Parent/legal guardian <u>MUST SIGN</u> medical history/consent <u>BEFORE</u> treatment begins for patients under 18 years of age.**

Declaration of Income and Insurance Information form

Some programs offer reduced fees based on income. To apply for a reduced fee, please provide the following information:

Number of family members in the household: _____

Total family income: $ _____ per Week or Month or Year (Circle One)

Which method of income verification applies to you:
** Proof of Income/support (example: pay stub, W2, support documents, etc.): _____

To participate in the **Uninsured Patient Dental Program** you must **PROVIDE PROOF OF INCOME/SUPPORT.** Self-Declared income for Family Planning and STD clients only.

I have health insurance coverage with the following: (Check all that apply)

☐ Medicaid
☐ Wellcare ☐ Peachstate ☐ Amerigroup ☐ CareSource
☐ Medicare
☐ Private Insurance

☐ I do NOT have health Insurance

☐ I do NOT have dental Insurance

My health insurance is NOT applicable due to the following: (Check all that apply)

☐ I am a Native American receiving healthcare services through the Indian Health service or a tribal organization
☐ I am in a period of exclusion under my health insurance plan
☐ I have exhausted my lifetime limits under my insurance plan
☐ I have limited scope coverage such as dental, vision, long term care or coverage for specific illnesses, not including family planning and/or breast and cervical cancer screening
☐ I have health insurance via a self-insured company that does not provide coverage for family planning and/or breast and cervical cancer screening

I understand that I may be asked to provide written proof of any insurance exclusion as indicated above (does not apply to family planning services). I understand that if I have insurance or fail to disclose insurance information, I will be held responsible for payment of services provided.

I understand that qualifying for any special discounted fees will be based upon the information regarding my income and number of dependents as listed above. I verify that the information I have given above is current and accurate. My signature below indicates that I have read or have had read to me the above regulations. I have had an opportunity to ask questions and understand the guidelines as listed above.

_____ _____
Client Signature Date

_____ _____
Interpreter Date

_____ _____
Health Department Witness/Title Date