MAHEC Dental Health Center at Biltmore

123 Hendersonville Road
Asheville NC 28803
2nd Floor of MAHEC Family Health Center

Appointments: (828) 252-4290
Mon-Thurs: 8:00 am – 5:00 pm
Friday: 8:00 am - 3:00 pm

MAHEC
Dental Health Centers

MAHEC Dental Health Center at Columbus

130 Forest Glen Road
Columbus NC 28722
On the campus of St. Luke's Hospital

Appointments: (828) 722-0003
Mon – Thurs: 8:00 am – 5:00 pm
Friday: 8:00 am - 12 noon

After hours, established patients can reach the dentist on call at 828-777-8925.

We are happy you have chosen MAHEC Dental Health Centers for your care!

We are an advanced training center which includes Dental Faculty, Dental Residents, and Pre-Doctoral Dental Students. From routine restorative procedures to cosmetic enhancement to periodontal disease management and dental implants, we are here to meet all of your oral healthcare needs. The dentists in our practice will provide you with comprehensive dental care in our state-of-the-art dental offices.

Our services include but are not limited to: cleanings and x-rays, cosmetic fillings, crowns, and veneers, custom partials and full dentures, Implants, reconstructive full-mouth dentistry, root canals, dental extractions, teeth whitening, periodontal (gum) disease treatments, and oral medicine.

We offer care for the entire family from children to the elderly. Our providers and staff always strive to provide evidence-based care in a professional, supportive atmosphere. We look forward to an on-going relationship with you and an exceptional patient experience at every appointment. At both our offices you'll find:

- Compassionate care—we treat patients like we would like to be treated.
- State-of-the-art services—featuring modern technology to enhance your dental experience.
- Patient-centered treatment—we'll work with you to develop a personalized treatment plan that supports your oral health goals.
- Experienced faculty members—who provide exceptional patient care and advanced training for the next generation of dental professionals.
- Emphasis on preventive care—so you can look and feel your best with healthy teeth and gums.
- Whole-health focus—we believe that oral health is an essential component of total wellness.

MAHEC Patient Registration Form

Please complete the following information using black ink. THIS INFORMATION IS CONFIDENTIAL.

☐ Dental Biltmore ☐ Dental Columbus

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Home Address: _____ Birth Sex: ☐ Male ☐ Female

City: _____ State: _____ ZIP: _____ SS#: _____

Home County: _____ Email Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

By providing a phone number, mobile phone number, or email address, I authorize MAHEC to contact me or my guardian/legal representative to remind me of appointments, to obtain feedback on my experience at this office, and to provide general health reminders and other information regarding my healthcare.

Special Hearing Needs:

_____

Special Vision Needs:

_____

Uses Wheelchair: ☐ Yes ☐ No

Speech Impaired: ☐ Yes ☐ No

Veteran Status: ☐ Yes ☐ No

Race (select one):

- ☐ Asian
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Black/African American
- ☐ American Indian/Alaska Native
- ☐ White
- ☐ More than one race

Ethnicity (select one):

- ☐ Hispanic or Latino/a
- ☐ Non-Hispanic or Latino/a

Gender Identity:

- ☐ Male
- ☐ Female
- ☐ Transgender Male
- ☐ Transgender Female
- ☐ Other
- ☐ Choose not to disclose

Sexual Orientation:

- ☐ Lesbian or Gay
- ☐ Heterosexual (or straight)
- ☐ Bisexual
- ☐ Something else
- ☐ Don't know
- ☐ Choose not to disclose

Preferred Language:

- ☐ English
- ☐ Spanish
- ☐ Russian
- ☐ American Sign Language
- ☐ Other: _____

Marital Status:

- ☐ Single
- ☐ In a relationship
- ☐ Partner
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

Special Populations

Migratory ☐ Yes ☐ No

Seasonal ☐ Yes ☐ No

Homeless ☐ Yes ☐ No

Homeless Status (select one):

- ☐ Not Homeless
- ☐ Homeless Shelter
- ☐ Transitional
- ☐ Doubling Up
- ☐ Street
- ☐ Permanent Supportive Housing
- ☐ Other

EMERGENCY CONTACT INFORMATION

Name: _____

Relationship: _____ Phone#: _____

IF PATIENT IS CHILD (UNDER 18)

Responsible Party Name: _____

Relationship: _____ Phone#: _____

Chart # _____

ANNUAL HOUSEHOLD INCOME BEFORE TAXES

_____ # of Individuals in Household: _____

The income information above is used for statistical information only and is not used to determine specific patient financial needs.

PRIMARY DENTAL INSURANCE INFORMATION

Insurance Company: _____ Policy ID#: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Policy Holder's Relationship to Patient: _____ Birth Sex of Policy Holder: ☐Male ☐Female

Policy Holder's Address: _____

SECONDARY DENTAL INSURANCE INFORMATION

Insurance Company: _____ Policy ID#: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Policy Holder's Relationship to Patient: _____ Birth Sex of Policy Holder: ☐Male ☐Female

Policy Holder's Address: _____

PRIMARY MEDICAL INSURANCE INFORMATION

Insurance Company: _____ Policy ID#: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Policy Holder's Relationship to Patient: _____ Birth Sex of Policy Holder: ☐Male ☐Female

Policy Holder's Address: _____

ASSIGNMENT OF BENEFITS AND FINANCIAL POLICY

I hereby authorize payment of all insurance, Medicaid, and/or Medicare benefits directly to MAHEC and I authorize them to file insurance on my behalf. I also authorize them to release medical and/or account information to my insurance, Medicaid, and/or Medicare carrier as required to satisfy claims. I agree to notify them should my coverage change.

I understand that MAHEC:

- Expects payment on the date of service (if insured, co pays and deductibles are expected on the date of service).
- Accepts cash, checks, debit cards or major credit cards.
- Expects Medicaid, Medicare and all insurance will be filed for me. However, it is my responsibility to know the details of my insurance coverage and provide MAHEC with current and accurate information.
- Provides services and treatment, which are medically appropriate. However, some of these may not be covered by my insurance plan and these will be my responsibility to pay.
- Expects my insurance company to pay within 90 days from the date of service and will bill me directly if the insurance does not pay.
- Expects the parent or guardian to pay for all services rendered to their dependents.
- Expects me to keep appointments and to call at least 24 hours prior, if I need to cancel. I understand that failure to do this may result in being discharged from the practice.

I have read and understand the above.

Patient or Parent/Guardian Signature: _____ Date: _____

Note: Failure to sign does not relieve you of the above expectations.

Chart # _____

CONSENT FOR TREATMENT

I voluntarily consent to routine services, medical treatment(s), diagnostic radiology procedure(s), diagnostic lab(s), behavioral health services, and services offered by lay health workers (e.g. doula, community health worker, peer support specialist) as deemed necessary by the healthcare providers treating me at any MAHEC facility. I voluntarily consent to allow MAHEC to seek emergency medical care from a physician or hospital, if needed. I understand that diagnostic procedures may include but are not limited to lab tests on blood, urine, and tissue, including drug screenings. I understand that diagnostic radiology procedures include but are not limited to x-ray, ultrasound, and/or mammography. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may cause injury or even death. I understand I have the right to ask questions about my treatment and/or procedures and the right to refuse any treatment or procedure. I agree to notify my provider of my concerns.

Patient or Parent/Guardian Signature: _____ Date: _____

ALTERNATIVE CONTACT AUTHORIZATION

I authorize MAHEC to discuss medical and financial information concerning the care and services provided to me with the individuals listed below:

Contact #1

Name: _____

Relationship: _____ Phone#: _____

Contact #2

Name: _____

Relationship: _____ Phone#: _____

Contact #3

Name: _____

Relationship: _____ Phone#: _____

NOTICE OF PRIVACY ACKNOWLEDGMENT

I have been given the opportunity to read MAHEC's Notice of Privacy Practices, and my questions concerning the Notice have been answered. I understand if I choose not to sign this acknowledgment, MAHEC will continue to provide services to me and will use and disclose my Protected Health Information (PHI) in accordance with MAHEC's Notice of Privacy Practices.

Patient or Parent/Guardian Signature: _____ Date: _____

MAHEC

FOR OFFICE USE ONLY
DOB:
Reviewed By:

Patient Information Sheet

We are a general dentistry practice and a teaching practice. We have dentists who are in a one-year advanced General Practice Residency and dental students who are in their final year at UNC Adams School of Dentistry. Our faculty and residents are dental school graduates. All students and residents are supervised by our faculty. We provide a complete range of dental care with only the most complicated cases referred out. Our fees for services are very competitive with other practices in this area. Please sign and date at the bottom of this page to acknowledge that you received this form and understand each policy.

Appointment Times:
We ask that all patients arrive 15 minutes before their appointed time in order to update records and verify dental insurance.

Appointment Confirmations:
Failure to confirm your appointment via text message or phone call through our automated reminder system at least 24 hours in advance will result in an appointment cancellation.

Emergency Appointments (Regular Business Hours):
If you are experiencing a dental emergency, please call the office after 8:15am. We will contact your doctor and make every effort to address your emergency situation as quickly as possible.

Pediatric Appointments, Minors/Guardians:
Children are able to receive treatment at our facility, however children seen are required to be able to be seen by the doctor in the treatment room on their own. Parents will be consulted after the exam or treatment is completed. If you are filling out paperwork or making treatment decisions for another individual, please indicate your relationship to the patient and provide legal documentation.

Unattended Children:
Please do not bring children to the dental center unless they have an appointment or a caretaker. For safety reasons, children are not permitted to accompany patients in the treatment areas and cannot be left unattended in the waiting room. The Dental Health Center and staff will not be able to monitor children.

Patients Only in Clinical Areas:
In order to provide the quality of care and the privacy we believe our patients deserve, we ask that spouses/parents/guardians remain in the reception area while treatment is in progress. This allows the doctor and clinical team to provide undivided attention to the patient. We are always glad to answer questions before, during, and after the procedure.

Supplemental Records Use: I consent to photography, video recording, and x-rays of my oral structures as related to these procedures, and for their education use in lectures or publications, provided my identity is not revealed.

Radiographs:
If you have had dental x-rays taken recently at another office, please request that copies be sent to our office before your appointment. Dental radiographs are needed to aid the dentist in assessing your oral health. Our office is equipped with the most modern and safest digital x-ray technology.

Medications:
Please bring a list of current medications that you are taking with you to your first appointment and every appointment thereafter if there are new prescriptions or changes in dosages.

Estimated fees:
Any fees quoted over the phone are estimates and not a guaranteed price for treatment. Written treatment plans and insurance estimates will be given before treatment is rendered.

After Hours Service:
Our Dental Office hours are generally from 8:00AM to 5:00PM, Monday through Friday. If you have a true dental emergency after hours; swelling, bleeding or facial trauma, please go to your nearest Emergency Department. You may also reach our on call doctor after hours at 828-777-8925.

Patient/Guardian/Parent Signature: _____Date:_____

Patient Name: _____

MAHEC

MAHEC Dental Health Center and Center for Advanced Training

HEALTH INFORMATION FORM

FOR OFFICE USE ONLY

Chart #: _____

Patient Name: _____

Date of Birth: _____

Reviewed by: _____

Date of last dental visit: _____ Reason for today's visit: _____

Please list all **medications**, supplements (including herbals), and over-the-counter medications you are currently taking.

_____ _____

_____ _____

_____ _____

_____ _____

Please list any **allergies**, including non-medical allergies (metals, latex, etc.)

_____ _____

_____ _____

_____ _____

_____ _____

WOMEN ONLY

Are you taking oral contraceptives?

☐ Yes ☐ No

Are you trying to get pregnant?

☐ Yes ☐ No

Are you pregnant?

☐ Yes (due date): _____

☐ No

Are you nursing?

☐ Yes ☐ No

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No

If yes, please provide details: _____

_____

_____

Have you ever taken Fosamax, Boniva, or any other medications containing Bisphosphonates? ☐ Yes ☐ No

If yes, are you currently taking **or** when was your last time taking? _____

_____

_____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

If yes, for what condition? _____

_____

Do you use, or have you ever used, any tobacco products (smoking, chewing, dipping, vaping, etc.)?

_____

MAHEC

MAHEC Dental Health Center and Center for Advanced Training

HEALTH INFORMATION FORM

FOR OFFICE USE ONLY

Chart #: _____

Patient Name: _____

Date of Birth: _____

Reviewed by: _____

In the following sections, please check if you currently have, have had, and/or are being treated for any of the below conditions.

Heart, Blood, and Cardiovascular

- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Stroke
- ☐ Chest Pain or Angina
- ☐ Irregular Heart Beat or A-fib
- ☐ Excessive Bleeding
- ☐ AID or HIV Positive
- ☐ Leukemia
- ☐ Infective Endocarditis
- ☐ Artificial Heart Valve
- ☐ Heart Failure
- ☐ Congenital Heart Problems
- ☐ Heart Murmur
- ☐ Bruise Easily
- ☐ Mitral Valve Prolapse
- ☐ Scarlet Fever or Rheumatic Fever
- ☐ Blood Transfusion
- ☐ Anemia
- ☐ Sickle Cell Disease
- ☐ Low Blood Pressure
- ☐ Pace Maker
- ☐ Other Heart Problems

Diabetes and Thyroid

- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Low Blood Sugar
- ☐ Excessive Thirst
- ☐ Recent Weight Loss

Skin, Joint, Muscle, Skeletal, Autoimmune, and Other

- ☐ Cancer
- ☐ Radiation Therapy
- ☐ Chemotherapy
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Artificial Joints
- ☐ Head or Neck Injury
- ☐ Pain in the Jaw Joints
- ☐ Glaucoma
- ☐ Fibromyalgia
- ☐ Lupus
- ☐ Cortisone Medications
- ☐ Swelling of the Limbs
- ☐ Gout
- ☐ Hives or Rash
- ☐ Dry Mouth
- ☐ Sores in or around Mouth
- ☐ Herpes, Shingles, or Other Venereal Diseases

Liver, Kidney, and Gastrointestinal

Hepatitis (choose): ☐ A ☐ B ☐ C

- ☐ Frequent Heartburn or Acid Reflux
- ☐ Kidney Problems
- ☐ Stomach Ulcers
- ☐ Frequent Diarrhea
- ☐ Other Kidney Problem
- ☐ Other Liver Disease or Problem

Breathing and Lungs

- ☐ Asthma
- ☐ COPD
- ☐ Sleep Apnea
- ☐ Shortness of Breath
- ☐ Tuberculosis
- ☐ Sinus Conditions or Trouble
- ☐ Frequent Cough
- ☐ Other Breathing or Lung Problems

Psychiatric and Neurologic

- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Anxiety
- ☐ Schizophrenia
- ☐ ADHD
- ☐ Dementia or Alzheimer's Disease
- ☐ Substance Use
- ☐ Seizures or Convulsions
- ☐ Developmental Disorders
- ☐ Autism (spectrum)
- ☐ Fainting Spells or Dizziness
- ☐ Other Psychiatric Condition

MAHEC

MAHEC Dental Health Center and Center for Advanced Training

HEALTH INFORMATION FORM

FOR OFFICE USE ONLY

Chart #: _____

Patient Name: _____

Date of Birth: _____

Reviewed by: _____

Do you have a Primary Care Provider? ☐ Yes ☐ No

If yes, please list name and phone number.

Name: _____

Phone Number: _____

Please list your preferred pharmacy.

Name: _____

Address: _____

_____

Phone Number: _____

Do you have any health problems that need further clarification? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent, or guardian: _____ Date: _____

MAHEC

SLIDING SCALE DISCOUNT PROGRAM

Compassionate financial support

Thank you for applying to our Sliding Scale Discount Program!

These documents will need to be turned in before your application can be processed:

- Completed Application
- Proof of Income

Please return all documents to your Patient Financial Advocate within 30 days of your first appointment.

Family Health Centers and Internal Medicine
Financial Advocate
Phone: (828) 771-3507
Fax: (828) 407-2640

Mailing Address:
123 Hendersonville Rd
Asheville, NC 28803

Ob/Gyn Specialists
Financial Advocate
Phone: (828) 771-5443
Fax: (828) 407-2639

Mailing Address:
119 Hendersonville Rd
Asheville, NC 28803

Center for Psychiatry and Mental Wellness
Financial Advocate
Phone: (828) 771-3460
Fax: (828) 820-8327

Mailing Address:
125 Hendersonville Rd
Asheville, NC 28803

Dental Health Centers
Financial Advocate
Phone: (828) 398-5918
Fax: (828) 552-8691

Mailing Address:
123 Hendersonville Rd
Asheville, NC 28803

If you have any questions regarding this program, please feel free to contact your Patient Financial Advocate at the numbers listed above.

Thank You!

Sliding Scale Discount Program

Compassionate financial support

Sliding Fee Discount Application

It is the policy of MAHEC to provide essential services for Medical, Behavioral Health, and Dental Care regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all essential services provided and billable by MAHEC. Services performed by outside organizations and equipment that is purchased from outside companies, including outside laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services, will not be covered under this policy. This form must be completed every 12 months or if your financial situation changes.

PATIENT NAME			DATE OF BIRTH
STREET ADDRESS			
CITY	STATE	ZIP	PHONE

Please list spouse and dependents

Name	**Date of birth**	**Needs Sliding Scale**	**Current MAHEC patient**
		❑ Yes ❑ No	❑ Yes ❑ No
		❑ Yes ❑ No	❑ Yes ❑ No
		❑ Yes ❑ No	❑ Yes ❑ No
		❑ Yes ❑ No	❑ Yes ❑ No
		❑ Yes ❑ No	❑ Yes ❑ No
		❑ Yes ❑ No	❑ Yes ❑ No

Annual Household Income for all working adults

Source	Self	Spouse	Other	Total
Last two pay stubs, tax form with schedule C if you are self-employed, or letter from employer				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other other miscellaneous sources				

NOTE: Copies of tax returns, pay stubs, or other information verifying income are required before a discount is approved.

I certify that the family size and income information shown above is correct.

Name (please print) _____ **Date** _____

Signature _____

Office Use Only

Approved by: _____
Date approved: _____
Family size: _____
Income: _____
Approved discount: _____
Date received signed agreement: _____

Verification Check List	Yes	No
Identification/Address: Driver's license, utility bill, employment ID, or		
Income: Prior year tax return, two most recent pay stubs, or other		

MAHEC Dental Health Center

123 Hendersonville Road, Asheville, NC 28803
130 Forest Glen Road, Suite A, Columbus, NC 28722
Business Office Phone: (828) 252-4290/Fax: (828) 333-5871 (Asheville)
Business Office Phone: (828) 722-0003/Fax: (828) 333-5460 (Columbus)

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR STUDENT TRAINING

***** You only need to fill out this form if you are being seen by a UNC dental student *****

Patient Legal Name: _____**DOB:**_____

I authorize the use or disclosure of my health information as described below.

The information is to be disclosed by:	**And is to be provided to:**
NAME OF FACILITY **MAHEC Dental Health Center**	NAME OF PERSON/ORGANIZATION/FACILITY **UNC -CH Adams School of Dentistry**
ADDRESS **123 Hendersonville Road/130 Forest Glen Road**	ADDRESS **Tarrson Hall**, **120 Dental Circle**
CITY/STATE/ZIP **Asheville, NC 28803/Columbus, NC 28722**	CITY/STATE **Chapel Hill, NC 27514** PHONE #: (919) 537-3737 FAX #: (919) 537-3625

The purpose for this disclosure is:

To permit MAHEC to disclose your protected health information to the faculty and administrative personnel of the UNC-CH Adams School of Dentistry so that they can assess one or more dental student's performance for grading purposes.

Information to be disclosed:

Your dental records for treatment provided to you by one or more dental student and any dental records for treatment ancillary to any such dental student's treatment.

I understand that this authorization will expire one (1) year from the date of service.

I understand that I may cancel this authorization at any time by notifying in writing the MAHEC Privacy Officer, 121 Hendersonville Road Asheville, NC 28803, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.

I understand that information used or disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state laws.

I understand that MAHEC will not condition treatment or eligibility for care on the provision of this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

By signing below, I acknowledge that I have read and understand this Authorization.

SIGNATURE OF PATIENT	DATE
SIGNATURE OF AUTHORIZED REPRESENTATIVE PATIENT, IF APPLICABLE *(State relationship to Patient)*	DATE
WITNESS TO SIGNATURE, IF APPLICABLE	DATE

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.