

ARE YOU A GOSHEN MEDICAL PATIENT: \_\_\_\_\_ YES \_\_\_\_\_ NO



Patient Registration Form Patient Number \_\_\_\_\_

Name: \_\_\_\_\_  
FIRST MI LAST

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex at Birth: ( ) Male ( ) Female  
PLEASE CHECK ONE

Social Security Number: \_\_\_\_\_

Street Address: \_\_\_\_\_ PO Box: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Telephone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ Email Address: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Student Status: ( ) Full Time ( ) Part Time  
PLEASE CHECK ONE IF APPLICABLE

Ethnicity (CHECK ONE): ( ) Hispanic/Latino ( ) Non-Hispanic/Latino Primary Language: \_\_\_\_\_

Race (CHECK ONE): ( ) American Indian/Alaska Native ( ) Asian ( ) Black/African American  
( ) Native Hawaiian ( ) Pacific Islander ( ) White ( ) More than 1 race

Spouse's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient's Employer: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Responsible Party Information: (Who Pays the Bills?) Guarantor Name: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Street Address: \_\_\_\_\_ PO Box: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Employer: \_\_\_\_\_

If Patient is a Minor:

Parent/Legal Guardian of Minor (1)

Name: \_\_\_\_\_  
FIRST MI LAST

Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

*Please Continue on Next Page*



Patient Registration Form (Page 2) Patient Number \_\_\_\_\_

Parent/Legal Guardian of Minor (2) [If Applicable]

Name: \_\_\_\_\_  
FIRST MI LAST

Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

(\*\*\*IMPORTANT NOTICE: The Parent/Legal Guardian Information Listed is Not Authorization and/or Designation of a Personal Representative\*\*\*)

Demographic Characteristics

Characteristics - Special Populations (Data used by Goshen Medical Center due to being a Federally Qualified Health Center which offers the Sliding Fee Discount based on family size and income.)

How long have you lived in the United States? \_\_\_\_ years, \_\_\_\_ months

Are you a US Veteran? ( ) Yes ( ) No

Persons In Household (PLEASE CIRCLE) 1 2 3 4 5 6 7 8 9 10 Other \_\_\_\_\_

Household Income Range (PLEASE CIRCLE):

<\$11,500 \$11,501-15,000 \$15,001-20,000 \$20,001-30,000 \$30,001-40,000  
\$40,001-50,000 \$50,001-60,000 \$60,001-70,000 \$70,001-80,000 \$80,001-90,000 >\$90,000

Within the last 24 months, have you or your parents worked in agriculture either on a farm or at an agricultural based industry? ( ) Yes ( ) No If yes, which applies? (PLEASE SEE BELOW)

- ( ) Year Round Employment (permanent residence in area)
- ( ) Migrant (establishes temporary residence in area)
- ( ) Seasonal (permanent residence in area)

Type of Housing for patient or patient's parent/guardian if a minor (CHECK ONE):

- ( ) Public Housing ( ) Homeless Shelter ( ) Doubled Up (live with another person or family unit)
- ( ) Rent or own Home ( ) Street ( ) Transitional (live place to place) ( ) Other \_\_\_\_\_

Sexual Orientation (CHECK ONE):

- ( ) Lesbian or Gay
- ( ) Straight (not Lesbian or Gay)
- ( ) Bisexual
- ( ) Something Else
- ( ) Don't Know
- ( ) Choose Not to Disclose

Gender Identity (CHECK ONE):

- ( ) Male
- ( ) Female
- ( ) Transgender Male/Female-to-Male
- ( ) Transgender Female/Male-to-Female
- ( ) Other
- ( ) Choose Not to Disclose

Is this visit due to an Accident/Injury: Yes \_\_\_\_ No \_\_\_\_ If yes, Date of Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_

I certify that the information given above is true and correct

\_\_\_\_\_  
(Patient Signature)

\_\_\_\_\_  
(Parent/Guardian signature if patient a minor)

\_\_\_\_\_  
(Print Name)

\_\_\_\_/\_\_\_\_/\_\_\_\_  
(Date)

NOTE: Receptionist may request payer source/insurance card or picture identification prior to being seen by provider.  
APR2016REV

Patient #:

Patient DOB:



DESIGNATION OF PERSONAL REPRESENTATIVE

This form must be completed, signed and dated in order to be considered a valid designation.

IMPORTANT NOTICE: ONE COMPLETED FORM IS REQUIRED FOR EACH DESIGNATED PERSONAL REPRESENTATIVE

PATIENT DESIGNATION OF A PERSONAL REPRESENTATIVE

Name of Patient:

I hereby designate the person listed below to be my personal representative and request that Goshen Medical Center, Inc. treat the named individual as it would otherwise treat me with regard to my Protected Health Information. I understand that this designation is voluntary. I understand that my disclosure of my protected health information carries with it the potential for an unauthorized re-disclosure and the information may no longer be protected by federal confidentiality rules.

PERSONAL REPRESENTATIVE INFORMATION

Name of Personal Representative:

Address of Personal Representative:

Phone # of Personal Representative:

Personal Representatives Relationship to Patient:

ACCESS TO PATIENT'S PROTECTED HEALTH INFORMATION

By signing this designation form, I am authorizing my personal representative access to:

- All Protected Health Information (e.g. Demographic, medical and billing information)
Health Information Only
Billing Information Only
Sensitive Health Information (e.g. HIV/AIDS status)
Mental Health
Appointment Information Only

EXPIRATION AND REVOCATION

This designation will expire on

I understand that I may revoke this designation of a personal representative at any time by submitting a written revocation to Goshen Medical Center Inc. Privacy Officer. I understand that I may revoke this designation at any time, except to the extent that action has already been taken to comply with this designation.

Signature of Patient: Date:

**MEDICAL HISTORY**

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_
- Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No \_\_\_\_\_
- Are you on a special diet?  Yes  No
- Do you use tobacco?  Yes  No
- Do you use controlled substances?  Yes  No

Women: Are you Pregnant/Trying to get pregnant?  Yes  No Taking oral contraceptives?  Yes  No Nursing?  Yes  No

Are you allergic to any of the following?  
 Aspirin     Penicillin     Codeine     Local Anesthetics     Acrylic     Metal     Latex     Sulfa drugs  
 Other If yes, please explain: \_\_\_\_\_

Do you have, or have you had, any of the following?

AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Angina	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Rheumatism	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Spina Bifida	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No
Breathing Problem	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Genital Herpes	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Convulsions	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No	Venereal Disease	<input type="radio"/> Yes <input type="radio"/> No
						Yellow Jaundice	<input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed above?  Yes  No

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_



Patient Consent for Treatment  
And  
Consent for and Acknowledgment of Receipt of the Notice of Privacy Practices

Patient Name: \_\_\_\_\_ Chart: \_\_\_\_\_

I understand that as part of my health care, Goshen Medical Center, Inc. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the Notice of Privacy Practices prior to signing this consent.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Goshen Medical Center, Inc. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Goshen Medical Center, Inc. has already taken action. I also understand that by refusing to sign this consent or revoking this consent, Goshen Medical Center, Inc. may refuse treatment. Upon refusal to sign this consent, I agree to assume the risk of any injury or damage from the lack of any medical care or treatment arising out of or in connection with Goshen Medical Center's denial to provide any medical care or treatment.

I further understand that Goshen Medical Center, Inc. reserves the right to change their notice and practices in accordance with federal regulations. Should Goshen Medical Center, Inc. change their notice, the revised Notice will be made available.

I understand that as part of Goshen Medical Center's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent.

I fully understand and decline the terms of this consent.

\_\_\_\_\_  
Patient's Signature / Guardian

\_\_\_\_\_  
Date

I hereby voluntarily consent to medical and/or dental examinations, treatments and procedures which are deemed necessary in the opinion of my physician, and health care providers, including HIV tests, laboratory tests and x-rays. I understand that my medical information is strictly confidential and is protected by NC General Statute 130A-143 and no guarantees or warranties have been made to me concerning the results of the examinations, treatments or procedures. My signature acknowledges that I have been given the opportunity to ask questions about this consent form.

\_\_\_\_\_  
Patient's Signature / Guardian

\_\_\_\_\_  
Date

The Federally Supported Health Centers Assistance Acts (FSHCAA) of 1992 (Pub. L. 102-501) and 1995 (Pub. L. 104-73) extend Federal Tort Claims Act (FTCA) protections under 28 U.S.C. 1346(b), 2401(b), and 2679-81 to eligible health centers funded under the Health Center Program, section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b), as amended. Goshen Medical Center, Inc. is protected under this legislation.



Rosewood Dental Services  
104C Adair Drive  
Goldsboro, NC 27530  
919-648-4437

Effective November 7, 2017

Any dental patient who misses three or more appointments at ANY of our offices will no longer be allowed to schedule appointments in advance.

We will still be willing to see patients in this situation, however it will then become the patient's responsibility to call when they know they can come, to see if we can accommodate them into our schedule within the next day or two. Every effort will be made to see a patient in this situation, but if the patient is not willing to do this, it will then be necessary for them to find another office.

We consider a missed appointment as any appointment a patient fails to show up for, or calls and cancels without giving our office enough time to fill the patient's appointment slot. Therefore, if it becomes necessary to cancel an appointment, please call our office as soon as possible. We recommend at least two days in advance.

Any patient who arrives later than their appointment time may be considered to have failed their appointment.

We always try to call and remind patients of their appointments as a courtesy, but this is not guaranteed. Once a patient makes an appointment with our office, IT IS THE PATIENT'S RESPONSIBILITY TO REMEMBER IT.

We will not make exceptions to this policy.

\_\_\_\_\_  
Signature of patient or guardian

\_\_\_\_\_  
Date



MR# \_\_\_\_\_

# "Self-Declaration" Sliding Fee Discount Program

We appreciate the opportunity to provide you with health services. All patient records are strictly confidential and cannot be released without your permission. Services rendered are expected to be paid on the date of service. The Sliding Fee Discount Program is based on total household size and income. In order to qualify, you must provide one of the following sources of information:

- Copy of most recent paycheck or paycheck stubs.
- Letter on agency letterhead verifying financial status, i.e., Social Security, Housing Authority
- Temporary Assistance for Needy Families documentation.
- Alimony and/or Child Support amount reported on sliding fee document.
- Dated letter from employer stating amount of gross payment (does not need to be notarized)
- Copy of Federal tax return or W-2's.
- Student Grant Information/SARs (Student Aid Reports) (self-declare on sliding fee
- If self-employed, tax forms from most current year (W-2's or 1099)
- Dated letter from head of household/family where patient resides stating financial responsibility.

### Self-Declaration of required information:

This document is only used during your initial visit under the Sliding Fee Discount Program

My current total household income is \$ \_\_\_\_\_

Total number of household members that you are financially responsible for \_\_\_\_\_

Name	DOB	Relationship

I have read the above information and understand the qualifications and documentation necessary to apply for the Sliding Fee Discount Program.

I further understand to bring income verification, if possible, upon the next visit, or within 6 months of the initial visit of the sliding fee calendar year. If I do not provide the necessary information, I will be required to pay 100% of charges for services received at Goshen Medical Center.

Patient Signature: \_\_\_\_\_ Date \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date \_\_\_\_\_

