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Astoria Sub-office
309-329-2922

Cuba Sub-Office
309-785-5300

FULTON COUNTY HEALTH DEPARTMENT

An Equal Opportunity Employer and Provider

FULTON COUNTY HEALTH DEPARTMENT - DENTAL CENTER

PATIENT REGISTRATION

First Name: _____ MI _____ Last Name: _____

Birthdate: _____ Age: _____ Home Phone: _____

Address: _____ CellPh: _____

City: _____ State: _____ Zip: _____

Medicaid Id#: _____ Other Insurance: _____

Pharmacy Name and Address: _____

Dr Name: _____ Estimated Annual Income: _____

(determines fee scale for pay clients)

IMPORTANT: PROOF OF INCOME OR CURRENT MEDICAID/ALLKIDS CARD MUST BE PRESENTED AT EACH APPOINTMENT.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (patient name) _____, hereby acknowledge that I received the "Notice of Privacy Practices" from the Fulton County Health Department dated April 14, 2003. I understand that the health department is already authorized to use the information gained to bill me, my insurance company, or any other potential sources of reimbursement, such as government programs in which I am enrolled or qualify for services. I also agree to allow release of treatment and/or appointment information to my child's school if necessary.

DATE

SIGNATURE