Welcome to Macon County Dental Services

Macon County Public Health

Macon County Public Health accepts Medicaid, NC Health Choice, patient pay and some private dental insurance plans. Sliding Fee payment options are available based on household size and income. **Proof of income is required** to qualify for the Sliding Fee. Payment is expected at time of service. We accept cash or personal checks. Your insurance will be billed but a copy of your insurance card is required.

Services offered include; cleanings, comprehensive & periodic exams, digital x-rays, extractions, fillings, preventive fluoride, sealants and limited emergency services. Patients that arrive more than 10 minutes past their appointment time will be required to reschedule.

If you would like to make an appointment or have further questions, please call **the Molar Roller for Children's Dental services at 828-349-2513** or visit: *www.maconnc.org* or *www.Facebook.com/MaconPublicHealth*. **Please use blue or black ink.**

PATIENT INFORMATION

First Name: _____ MI: ____ Last Name: _____

Preferred Name: _____ Date of Birth: _____

Contact: Cell: _____ Home: _____

Email: _____

Gender: ◯ Male ◯ Female

Social Security: _____ County of Residence: _____

Address: _____

City: _____ State: _____ ZIP: _____

Race: [ ]White [ ]White - Hispanic Origin [ ]Black or African American
[ ]American Indian or Alaska Native [ ]Asian/Pacific Islander [ ] Other: _____

Interpreter Needed? ◯ Yes ◯ No If yes, Language: _____

Previous Dentist: _____

Address: _____

Last Visit: _____ Phone: _____

SCHOOL INFORMATION

◯ Macon County Public School
◯ Macon Program for Progress (MPP)
◯ Homeschooled
◯ Private
◯ Other _____

*Please complete the following section if your child attends a Macon County Public School.

School Name: _____
Teacher: _____
Grade: _____

PARENT/GUARDIAN INFORMATION

Mother: _____ Phone: _____

Father: _____ Phone: _____

Legal Guardian: _____ Relationship: _____ Phone: _____

List Other Persons Living In Home (use back of form if additional space req.)	DOB	Sex	Relationship to Patient

INSURANCE INFORMATION

◯ No Dental Insurance/ Self-Pay

Name of Insurance Company: _____

Policy Holder Name: _____ Member ID: _____

A copy of the insurance card is required.

Phone: 828-421-4532 Fax: 828-524-0315