MASCOMA COMMUNITY HEALTH CENTER

New Patient Information - DENTAL

We are committed to meeting the needs of our patients. Our entire team wants to make sure your experience at the Health Center is positive, and that you will return when you require our services, again. We strive to offer quality dentistry, while working with our patients to create affordable treatment plans.

Before Your First Visit…

There are a few steps that we ask to be completed before your first appointment. These are:

1. Complete, sign, and return a New Patient Dental Packet to us so that we can enter your information into our electronic health record.

2. The New Patient Dental Packet includes the Release of Information. These are for us to get information about any dental care that you may have had in the past, including X-rays, exams, dental surgery, etc. Please fill these forms out completely, and sign at the bottom, so that we can send them to your previous dental office and get the information BEFORE you come for your first appointment with us.

3. If there is anything in the New Patient Dental Packet that you don't understand, or have a question about, please call us or stop by. We are happy to help with these forms.

At Your First Visit…

This is what to expect at your initial visit at the dental clinic:

4. All new patients must meet with our Dentist for a "comprehensive oral exam." This means that he will look closely at your mouth and teeth to determine how healthy these are, and check out any issues or problems that you may be having.

5. Our Dentist and assistant will also ask questions of you to determine what your past dental care may have been, and verify any records that we have gotten from your prior dentist(s).

6. <u>If you have not had dental X-rays in a while, or, if we were unable to get recent ones from your prior dentist, we will need to take X-rays here</u>, so that we have current films of the state of your mouth/teeth. These are very important in helping the dentist and staff develop a diagnosis and treatment plan for you.
   A TIP ABOUT X-RAYS: In order to get clear X-rays, we ask that you do not wear any jewelry, including necklaces, earrings, nose rings, etc. to your appointment.

PAYING FOR YOUR VISIT…

And some information about billing:

7. We accept cash, credit cards, or insurance plan payment. Please bring any insurance information and insurance cards with the subscriber identification. We accept many insurance plans. It is our policy to bill the insurance companies on your behalf however, <u>any unpaid balances are the patient's responsibility</u>. Please also see payment policy that is attached to your New Dental Patient Packet.

8. If you need financial assistance, please ask our front office staff about our discount, payment plans, or eligibility for the Sliding Fee Scale program.

MASCOMA COMMUNITY HEALTHCARE, INC.
PO BOX 550 ~ 18 ROBERTS ROAD
CANAAN, NH 03781 ~ 603-523-4343

Dental History Form

Patient Name:_____ Date of Birth:_____ Today's Date:_____
Occupation _____ Phone number: _____

When was your last dental visit? _____ Reason? _____
Name of your last dentist? _____ When were your last X-Rays taken? _____
Have you had any periodontal (gum) treatment? [ ] yes [ ] no
Do you wear any removable dental appliances (complete denture, partial denture)? [ ] yes [ ] no
How often do you brush your teeth? _____ Floss?_____

Do you or have you ever had the following

[ ] Bleeding or sore gums	[ ] Clenching or grinding	[ ] Shifting of teeth
[ ] Unpleasant taste or bad breath	[ ] Sensitivity to hot	[ ] Change in bite
[ ] Burning of tongue or lips	[ ] Sensitivity to cold	[ ] Dry mouth
[ ] Frequent blisters on lips or in mouth	[ ] Sensitivity to sweet	[ ] Headaches
[ ] Swelling or lumps in mouth	[ ] Sensitivity to biting	[ ] Loose teeth
[ ] Clicking or popping of jaw	[ ] History of locked jaw	[ ] Food impaction

Do you like your teeth or smile [ ] yes [ ] no
Are you currently experiences a dental problem [ ] yes [ ] no

_____

Goals for dental treatment

_____

_____

Have you had a serious/difficult problem associated with any previous dental treatment?

_____

Have you ever taken Bisphosphonate drugs or drugs for bone density or osteoporosis? [ ] yes [ ] no
Have you ever been told to premedicate with antibiotics before dental procedures? [ ] yes [ ] no
Have you ever had head and neck radiation or chemotherapy? [ ] yes [ ] no
Are you currently taking any blood thinners? [ ] yes [ ] no
Are you currently taking any corticosteroid medications? [ ] yes [ ] no

Current or former tobacco use [ ] yes (list frequency/# years) _____ [ ] no
Current or former marijuana use [ ] yes (list frequency/# years) _____ [ ] no
Current or former drug abuse [ ] yes (list frequency/# years) _____ [ ] no
Drinks of alcohol per week [ ] yes (list frequency/# years) _____ [ ] no

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Past Medical History: (Please check all that apply)

[ ] High blood pressure	[ ] Asthma	[ ] Colitis	[ ] HIV
[ ] High cholesterol	[ ] Emphysema	[ ] Hepatitis	[ ] Herpes
[ ] Pacemaker	[ ] Tuberculosis	[ ] Blood clots	[ ] Depression
[ ] Congestive heart failure	[ ] Diabetes	[ ] Anemia	[ ] Anxiety
[ ] Heart attack	[ ] Arthritis	[ ] Blood transfusion	[ ] Cancer
[ ] Coronary artery disease	[ ] Thyroid disorder	[ ] Bleeding disorders	[ ] Glaucoma
[ ] Stroke	[ ] Seizure disorder	[ ] Kidney disorder	[ ] Mental disability
[ ] Dementia/Alzheimers	[ ] Joint replacement	[ ] Radiation therapy	[ ] Physical disability
[ ] Acid reflux	[ ] Osteoporosis	[ ] Chemotherapy	[ ] Eating disorder

Past surgical history: (Please listy type of surgery and approximate date of surgery)

_____

_____

_____

Other personal medical problems or hospitalizations

_____

_____

_____

Medications: (List all prescribed medications, over the counter medications, vitamins, supplements, and herbs)

Medication name Strength Frequency

_____

_____

_____

_____

_____

_____

Allergies: [ ] yes (please list below) [ ] No known allergies

Allergy Type of reaction

_____

_____

_____

MASCOMA COMMUNITY HEALTH CENTER

PATIENT REGISTRATION FORM

Welcome to Mascoma Community Health Center! We realize that the paperwork in our New Patient Packet takes some time and thought to fill in, but, we want to make sure that our providers have the information they need to take care of you, and your medical record is complete and up to date. Thank you for helping us to make your health care experience a good one!

Patient Information: Name: (First) _____(Middle)_____(Last)_____Suffix(Jr., Sr., etc.)_____

Previous Last Name:_____ Address (Street or PO Box, City, State, Zip):_____

Home Phone: (__)_____ Cell Phone: (__)_____ Work Phone: (__)_____ Email:_____

Is it OK to leave a message at these numbers: ☐ Yes ☐ No If yes, please select: ☐ Appointment. info only ☐ Appt. & Medical Info How would you like us to communicate with you (check all that apply): ☐ Phone call ☐ Text message ☐ Patient Portal

Date of Birth:_____ Sex: ☐ Male ☐ Female ☐ Unknown ☐ Transgender-Male/Female-To-Male ☐ Transgender-Female/Male-To-Female ☐ Choose not to disclose

Marital Status: ☐ Divorced ☐ Married ☐ Partner ☐ Single ☐ Unknown ☐ Widowed ☐ Legally Separated

Social Security Number _____-_____-_____

Employer Name: _____ Address: _____

Employment Status: ☐ Full-time ☐ Part-time ☐ Not employed ☐ Self-employed ☐ Retired ☐ Disabled ☐ Military – Active ☐ Military – Reserves ☐ Unknown ☐ Student Full-time ☐ Student Part-time

Are you a U.S. Veteran? ☐ Yes ☐ No Branch of Military Service _____ Number of years of service:_____

Responsible Party Information (Who is Responsible for Paying the Bill): ☐ Self ☐ Other person (fill in below)

Last Name_____First Name_____Middle Name:_____

Address:_____City_____State_____Zip _____

SSN_____-____-_____DOB:_____ Home Phone:( )_____ Work Phone:( )_____

Cell Phone: ( )_____Relationship to Patient:_____

Emergency Contact (Fill in if there is someone you want us to contact in the event of an emergency):

Relationship to you: _____ Is this person your legal guardian: ☐ Yes ☐ No Can we also share your medical information with his person: ☐ Yes ☐ No Contact's Name:_____ Address:_____

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

Pharmacy Information: Your local pharmacy name:_____ Location:_____

Phone Number:_____ Mail Order Pharmacy Name (if applicable):_____

Address:_____ Phone Number:_____

MASCOMA COMMUNITY HEALTH CENTER

PATIENT REGISTRATION FORM

****Prescription History Consent: I hereby give Mascoma Community Healthcare, Inc., permission to obtain a history of my prescribed drugs, during the course of my medical care.**

BY: _____ (patient signature) MCHC Witness _____ Date: _____

Primary Insurance Information: Name of Insurance:_____ Policy Number:_____Group Number:_____

Name on Insurance Card: _____ Insurance Is Provided to Patient By: ☐ Self ☐ Spouse ☐ Parent ☐ Other (specify)_____

Secondary Insurance Coverage Information: Name of Insurance:_____Policy Number:_____

Group Number:_____ Name on Insurance Card: _____

Insurance Is Provided to Patient By: ☐ Spouse ☐ Parent ☐ Self ☐ Other _____(specify)

We are required to collect the following information because we receive federal funding. It is always kept CONFIDENTIAL, as part of your medical record:

Sexual Orientation: ☐ Lesbian ☐ Gay ☐ Straight ☐ Bisexual ☐ Something Else ☐ Choose Not to Disclose

Legal Sex: ☐ Male ☐ Female **Sex as listed on your Insurance**: ☐ Male ☐ Female

Primary Language Spoken: ☐ English ☐ Spanish ☐ Other_____**Will you Need Interpreter Services**? ☐ Yes ☐ No

Race: ☐ Asian ☐ Black / African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ American Indian/Alaskan Native ☐ Other/Refused to Report

Ethnicity: ☐ Hispanic ☐ Non-Hispanic or Latino ☐ Refused to Report

Are you Homeless? ☐ No ☐ Yes (**If Yes**) → ☐ Homeless Shelter ☐ Transitional ☐ Doubling up ☐ Street ☐ Other

Are you a Migrant Worker? ☐ Yes ☐ No **Are you a Seasonal Worker**? ☐ Yes ☐ No

How many people currently live in your household (Including yourself): _____

Yearly Household Income (please check one): ☐ Less than $22,340. ☐ $22,341 to $30,260. ☐ $30,261. to $38180. ☐ $38,181. to $46,100. ☐ $46,101. to $54,020. ☐ $54,021. to 61,941. or more **If decline to answer, initial here:**_____

_____	_____	_____
Signature of Patient/Legal Representative	Printed Name of Patient/Representative	Date

MASCOMA COMMUNITY HEALTH CENTER

RELEASE OF INFORMATION FORM

Release (Disclosure) of Your Protected Health Information To Persons of Your Choice

Mascoma Community Health Center (MCHC) will release your protected health information to a person or persons whom you choose. However, you must give us the name(s) and phone numbers of the person(s), tell us what information we are allowed to disclose, and authorize us to do this by signing your name on this form. **If you do not want your protected health information released to anyone, disregard this form.**

Contact #1: Release information to the following person and for the purpose(s) as 'checked' below:

Name:_____ Relationship:_____ Phone:_____ Other Phone:_____

I give permission for MCHC to give the above-named person information about the following: (check all that apply):
___ Appointment information (date, time, with whom, for what)
___ Information and results from any tests or diagnostics such as labs, X-rays,
and other clinical information such as medications, diagnoses, prognoses, etc.
___ Emergency contact, only

Contact # 2: Release information to the following person and for the purpose(s) as 'checked' below:

Name:_____ Relationship:_____ Phone:_____ Other Phone:_____

I give permission for MCHC to give the above-named person information about the following: (check all that apply):
___ Appointment information (date, time, with whom, for what)
___ Information and results from any tests or diagnostics such as labs, X-rays,
and other clinical information such as medications, diagnoses, prognoses, etc.
___ Emergency contact, only

Signed:_____ Date:_____

MASCOMA COMMUNITY HEALTH CENTER

RELEASE OF INFORMATION FORM

AUTHORIZATION FOR RELEASE OF INFORMATION 2018

HIPAA COMPLIANT RELEASE

Patient's Name:_____DOB: _____

Release of Information ***FROM:*** _____

TO: ***Mascoma Community Health Center***
PO Box 550
Canaan, NH 03741
ATTN: MEDICAL RECORDS DEPT.
Phone: 603.523.4343 Fax: 866.277.5893
Dental Records can be emailed to dentalrecords@mascomahealth.org

I hereby authorize and request the exchange of information between Mascoma Community Healthcare and the above-named individual/organization. The following information is requested to be shared:

☐ **All**

☐ Office Notes	☐ Intake Assessment	☐ Test Results
☐ Psych/Social/Emotional Evaluation	☐ Medications	☐ Treatment Plan
☐ Immunizations	☐ Summaries	☐ Discharge Summary
☐ Counselor Reports	☐ Teacher Reports	

Date range of records to release (check one): ☐ Only documents from_____to_____ ☐ All dates

Reason for Request_____

Form of Disclosure (check all allowed): ☐ Written ☐ Verbal ☐ Electronic

☐Release of confidential information is subject to State and Federal Laws. By signing this release, I acknowledge my permission to release the above information to and/or from the individual or agency I have named which may include drug and alcohol abuse information.
Note: Federal regulations govern the confidentiality of alcohol and drug dependent persons (42CFR Par 2). Federal Law prohibits the disclosure of (1) psychotherapy notes, (2) information compiled in reasonable anticipation, or for the use in civil, criminal, or administration action or proceedings.

☐I understand I may revoke this authorization at any time by notifying **Mascoma Community Healthcare Inc.,** in writing, except to the extent that: a) action has been taken in reliance on this authorization; or, b) if this authorization is obtained as a condition or obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.
☐I understand I have a right to request and receive a **Notice of Privacy Practices** for Mascoma Community Healthcare, Inc.,

☐All releases expire one year from the date signed, unless otherwise indicated. Optional expiration date:_____
☐I hereby authorized the following; (please initial if applicable)__Disclosure of the results of HIV antibody blood testing and/or information concerning AIDS (Acquired Immune Deficiency Syndrome).

_____	_____	_____	_____
(Signature of Patient or Representative)	(Printed Name)	(Relationship to Patient if Representative)	(Date)

_____	_____	_____
(Witness Signature)	(Printed Name)	(Date)