MASCOMA
COMMUNITY
HEALTH CENTER

Dental New Patient Intake Paperwork

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 that your dental record is complete and up to date. Thank you for helping us to make your dental experience a good one!

Office Use Only
Date Received: _____

Patient Information

Name: _____ Date of Birth: _____

Mailing Address: _____ Social Security Number: _____

City/State/Zip: _____ Sex: ◯ Female ◯ Male ◯ Other

Physical Address Same as Mailing? ◯ Yes ◯ No If not: _____

Preferred Phone: _____ ◯ Home ◯ Mobile ◯ Work

Secondary Phone: _____ ◯ Home ◯ Mobile ◯ Work

Email: _____

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

Employer: _____ 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 Veteran? ◯ Yes ◯ No Branch of Military Service: _____ Years of Service: _____

Insurance Information

Policy Holder: _____ Policy Holder Date of Birth: _____

Relationship to Patient: ◯ Self ◯ Spouse ◯ Parent ◯ Other _____

Primary Insurance Carrier: _____

Policy Number: _____ Group Number: _____

Insurance Type: ◯ Private ◯ Medicare ◯ Medicare Advantage ◯ Medicaid ◯ Tricare

Do you have a secondary insurance? ◯ Yes ◯ No If yes: _____

Responsible Party (Who is Responsible for Paying the Bill)

◯ Self ◯ Other person (fill in below)

Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Phone: _____ Social Security Number: _____ Relationship to Patient: _____

Emergency Contact

Is this person your legal guardian? ◯ Yes ◯ No

Can we share your medical information with this person? ◯ Yes ◯ No

Name: _____ Relationship to Patient: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

Pharmacy Information

Preferred Pharmacy: _____ Location: _____

Mail Order Pharmacy (if applicable): _____

Additional Information

Because we received federal funding, we are required to collect the following information. 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 Spoked: ◯ 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/Latino ◯ Non-Hispanic/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 live in your household (including yourself)? _____

Yearly Household Income: ◯ Less than $22,340 ◯ $22,341 to $30,260 ◯ $30,261 to $38,180
◯ $38,181 to $46,100 ◯ $46,101 to $54,020 ◯ $54,021 to $61,941 or more ◯ Refuse to Report

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

I attest that the information provided on this form is true and accurate.

_____ _____

Patient Signature Date

Mascoma Community Health Center
Dental History Form

Name: _____

DOB: _____

When was your last dental visit? _____

Reason for last dental visit? _____

Name of your last dentist? _____

When were your last x-rays taken? _____

Have you ever had periodontal (gum) treatment? ◯ Yes ◯ No

Do you wear any removeable dental appliances (complete denture, partial dental)? ◯ Yes ◯ No

How often do you brush your teeth? _____ Floss? _____

Do you experience any of the following? (Check all that apply)

☐ 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

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Do you like your teeth/smile? ◯ Yes ◯ No

Are you currently experiencing a dental problem? ◯ Yes ◯ No

If yes, please explain: _____

What are your goals for dental treatment? _____

Have you had a serious/difficult problem associated with any previous dental treatments? ◯ Yes ◯ No

If yes, please explain: _____

Are you pregnant or currently breastfeeding? ◯ Yes ◯ No

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/or neck radiation or chemotherapy? ◯ Yes ◯ No

Are you currently taking any blood thinner medications? ◯ Yes ◯ No

Are you currently taking any corticosteroid mediations? ◯ Yes ◯ No

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Are you a current or former user of tobacco products? ◯ Yes ◯ No If yes, frequency and duration: _____

Are you a current or former user of marijuana? ◯ Yes ◯ No If yes, frequency and duration: _____

Do you currently or have you every abused drugs? ◯ Yes ◯ No If yes, frequency and duration: _____

Do you drink alcohol? ◯ Yes ◯ No If yes, list drinks/week: _____

Mascoma Community Health Center
Dental History Form, continued.

Medications

List all prescription medications, over-the-counter medications, and supplements that you take on a regular basis.

Medication	Dose	Directions

Allergies/Intolerances

Allergen	Reaction

Surgeries

Any complications from surgery or anesthesia? If yes, explain: _____

Date	Surgery	Hospital

Hospitalizations

Date	Reason	Hospital

Medical History (Check all that apply)

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Pacemaker
- ☐ Congestive Heart Failure
- ☐ Heart Attack
- ☐ Coronary Artery Disease
- ☐ Stroke
- ☐ Dementia/Alzheimer's
- ☐ Acid Reflux
- ☐ Asthma
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Arthritis
- ☐ Thyroid Disorder
- ☐ Seizure Disorder
- ☐ Joint Replacement
- ☐ Osteoporosis
- ☐ Colitis
- ☐ Hepatitis
- ☐ Blood Clots
- ☐ Anemia
- ☐ Blood Transfusion
- ☐ Bleeding Disorder
- ☐ Kidney Disorder
- ☐ Radiation therapy
- ☐ Chemotherapy
- ☐ HIV
- ☐ Herpes
- ☐ Depression
- ☐ Anxiety
- ☐ Cancer
- ☐ Glaucoma
- ☐ Mental Disability
- ☐ Physical Disability
- ☐ Eating Disorder

MASCOMA
COMMUNITY
HEALTH CENTER

Authorization for the Release of Information
HIPAA COMPLIANT RELEASE

Mascoma Community Health Center
PO Box 550/18 Roberts Road
Canaan, NH 03741
Phone: 603-523-4343
Fax: 866-277-5893
dentalrecords@mascomahealth.org

Patient's Name:_____DOB: _____

Release of Information ***TO / FROM*** *(circle one)**:***

Facility Name: _____
Address: _____
Phone/Fax: _____

TO / FROM *(circle one)**:*** ***Mascoma Community Health Center***

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:

O **All MEDICAL** O **All DENTAL**

O **Only those items which are pertinent to this referral**

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

Date range of records to release (check one): O Only documents from _____ to _____ O All dates

Reason for Request _____

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

O 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.
O 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.
O I understand I have a right to request and receive a **Notice of Privacy Practices** for Mascoma Community Healthcare, Inc.,
O All releases expire one year from the date signed, unless otherwise indicated. Optional expiration date: _____
O 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)

Mascoma Community Health Center
Consent to Treat, Guarantee of Payment, and Acknowledgement of Notice of Privacy Practices

I. CONSENT TO TREAT: I, the patient identified below, or the parent or legal guardian of the patient identified below (the "Patient"), consent to receive health services from Mascoma Community Health Center ("MCHC"). This service may include diagnostic tests and/ or procedure(s), treatments and/ or tests that a physician, nurse practitioner(s), clinician, and other professional staff member(s) (each a "Provider") deems to be necessary and advisable in regards to my specific care plan. The name, credentials, licensure/certification, and/ or qualifications of the Provider providing my care is available upon request.

I understand that services may include routine or specialized diagnostic tests and procedures up to and including the administration or injection of pharmaceutical products and medications, and the withdrawal of blood for laboratory examinations. I understand that no guarantees have been made to me as to the results or effectiveness of treatments or examinations performed by MCHC personnel.

I understand that as part of the diagnostic process, my health condition may necessitate that the Provider obtain a photograph or image in certain situations (i.e., wound care). I consent and agree to the use of this image and acknowledge that it may be necessary when providing quality healthcare services. I understand that all or a part of the image may become part of my medical record.

I acknowledge that in cases where the Patient discloses the intent to harm to self or others, or instances of past or present child neglect or abuse, disclosure and/or mandated reporting may result in accordance with applicable local, state or federal law and/or MCHC's policies and procedures.

I authorize MCHC to retrieve and store relevant treatment history through a health information exchange as permitted by state law and to use and disclose PHI as permitted under the Health Insurance Portability and Accountability Act ("HIPAA"), HITECH, other applicable law, and by MCHC's Notice of Privacy Practices. I understand that I may choose to opt out of the health information exchange, pursuant to applicable state law.

I understand that I will have access to my medical record through MCHC's Patient Portal. I may obtain copies of such records from the Patient Portal for my own use. Alternatively, I may request a copy of my medical records by filling out an Authorization to Release Protected Health Information through the Health Information Management (HIM) department. A form is available for pick-up at the practice or by calling (603) 523-4343.

Medical Visits for Adolescent during School Hours

I understand that, in some instances, such as when the Patient is in school or elsewhere, that the parent or legal guardian my not be available to accompany the adolescent to an appointment. If the patient is over 16 years old and if I so choose to allow them to attend an appointment without a parent or legal guardian present, I will complete an Authorization to Treat a Minor Child Form in advance and submit to MCHC's HIM Department.

I understand that the Provider will not prescribe to the Patient any new medications or controlled substances under federal law, without consulting and getting informed consent of the parent or guardian. I agree that MCHC will not be held responsible for any accidents, events or incidents that may occur before or after the office visit or during transportation to the Patient's appointment.

(over)

II. RELEASE OF INFORMATION: I hereby consent to the use and disclosure of the Patient's health information for purposes of treatment, payment and to facilitate MCHC's health care operations as described in the Notice of Privacy Practices. I hereby authorize and direct MCHC to release to government agencies, insurance carriers, managed care companies, or other entities who are or may be financially liable for the Patient's medical care (and to authorized agents of such entities) all information needed to substantiate payment for this medical care and to permit representatives thereof to examine and request copies of records related to the Patient's case and medical treatment. I further authorize MCHC to release billing information to any healthcare provider the Patient chooses or who may be involved in the Patient's care.

III. ASSIGNMENT: I hereby assign, transfer and set over to MCHC sufficient monies and/or benefits to which I am or may be entitled from government agencies, insurance carriers, or others who may be financially responsible for the Patient's medical care to cover costs of the care and treatment rendered.

IV. PATIENT GUARANTEE OF PAYMENT: I accept that I am financially responsible for all services rendered on the Patient's behalf for which a charge may be associated. I accept personal responsibility for all co-payments, deductibles, and non-covered services, as dictated by my or the Patient's insurance coverage (hereinafter, the "insurance plan"), plus any collection costs for amounts personally owed by me. I acknowledge that there may be services provided by MCHC that may not be covered by the insurance plan for one or more reasons, including but not limited to exclusions under the insurance plan, exhaustion of benefits, the insurance plan's designation of MCHC as an out-of-network provider, and/or my failure to provide the insurance card. I understand that if I do not fulfill the requirements of the insurance plan, do not receive the requisite prior approval, if the authorization is denied, or if the insurance plan refuses to pay the cost of the telemedicine services for any other reason, I understand and agree that I am financially responsible for the cost of these services.

If the insurance plan sends me, or the Patient, money that is designated to pay for the services provided by MCHC, I agree to promptly send the check or an amount equal to the amount received by the insurance plan to MCHC. I understand that all bills are to be paid immediately upon receipt. Should a medical bill create an unexpected financial hardship, I will contact MCHC to discuss payment arrangements. I also understand that in the event my account is transferred to a collection agency due to my failure to pay for services, that I will be responsible for any reasonable attorney's fees and costs collection fees and costs incurred by MCHC in collecting payment, in addition to the amount of the bill.

V. HIPAA ACKNOWLEDGEMENT: I understand that MCHC has a Notice of Privacy Practices that contains a description of the permissible uses and disclosures of my health information. I further understand that MCHC may update its Notice of Privacy Practices at any time, and that I may receive an updated Notice of Privacy Practices by submitting a request in writing to MCHC or by accessing the most current Notice of Privacy Practices online at www.mascomacommunityhealth.org. I acknowledge that a copy of MCHC's Notice of Privacy Practices is posted in the lobby and understand that I may request a copy of this Notice in the future.

VI. AFFIRMATION: I affirm that I have read and fully understand this Consent to Treat, Guarantee of Payment, and Acknowledgement of Notice of Privacy Practices form and have been given the opportunity to ask questions and that all my questions have been answered to my satisfaction.

Print Patient Name	Signature of Patient/ Legal Representative/ Guardian	Date

Authority/ Relationship of Representative to Patient

MASCOMA COMMUNITY HEALTHCARE, Inc.

Informed Consent: Dental Services

I hereby give consent for myself/ my child to receive treatment deemed necessary by the dental providers at Mascoma Community Healthcare, Inc. These procedures may include, but are not limited to; examinations, oral prophylaxes (cleanings), fluoride treatments, sealants, restorations (amalgam or composite fillings and crowns), periodontal (gum) treatments, extractions, and the use of local anesthetics.

I understand my/ my child's dental condition(s) and have discussed treatment options with my/ my child's provider. I will be given a printed copy of the treatment plan.

I understand there are risks inherent in general dental treatment(s). The potential risks and complications, include, but are not limited to, the following:

- Drug reactions and side effects.
- Damage to adjacent teeth or tooth restorations.
- Necessity for further treatment based on findings during treatment (like a pulp exposure, further decay, or unsupported tooth structure) or as a result of treatment.
- Breakage or dislodgement of filling material.
- Tooth sensitivity
- As a result of injection of local anesthesia, there may be swelling, bruising, jaw muscle tenderness, allergic reaction, numbness, tingling, changes in pain perception (that in rare cases may be permanent), and/or prolonged anesthesia.

I understand that each dental procedure or course of treatment has an expected result. I further understand that these results cannot be guaranteed and may not be achieved. I am aware of my right to refuse treatment of any kind and I am aware of the possible consequences of non-treatment.

I understand that I have an electronic dental record that is separate from my medical health record. I have disclosed my health history information, including allergies, reactions to medicine, diseases, and past procedures to the best of my knowledge. I understand that withholding any medical information may affect the outcome of my dental procedure(s) or course(s) of treatment.

I authorize any necessary life-saving procedures to be performed in the event of an emergency during the procedure(s) or course(s) of treatment. I give my consent for the administration of any medication that may be required as a life-saving measure.

I understand that fees are due at the time of service, and I am responsible for paying all fees that are not covered by my insurance. All fees and insurance information have been explained to me.

I understand that this consent shall be considered in effect until rescinded or revoked in writing by the patient, parent, or legal guardian.

I have had the opportunity to discuss the risks and benefits of receiving dental treatment(s) with my/ my child's provider and/ or treatment team and all my questions have been answered to my satisfaction. I hereby consent to dental treatment.

_____	_____	_____
Print Patient Name	Sign. of Patient/ Representative/ Guardian	Date

_____

Authority/ Relationship of Representative to Patient

Mascoma Community Healthcare **Designation of Personal Representative**	Name: _____ DOB: _____ Account #: _____ Phone #: _____ Address: _____

I hereby designate the following Personal Representative to assist me in exercising my health information rights under the New Hampshire Patient's Bill of Rights (NH RSA 151:19-21) and the Federal Privacy Rule (45 CFR 64.502(g)), as indicated below.

My designated Personal Representative is:

Name: _____ Phone #: _____

Address: _____

My Personal Representative has the authority to execute on my behalf any releases or other documents that may be required in order to exercise my health information rights.

I request that my Personal Representative be allowed to assist me in exercising the following rights related to my protected health information **(please check all applicable items)**:

- ☐ Restrictions _____
  _____
- ☐ The right to access and obtain a copy of my medical records and other protected health information;
- ☐ The right to authorize use or disclosure of my protected health information;
- ☐ The right to request an amendment of my protected health information;
- ☐ The right to request an accounting of disclosures of my protected health information;
- ☐ The right to communicate verbally regarding my appointments;
- ☐ The right to have verbal communication with my health care team;
- ☐ Other (please specify): _____
  _____
- ☐ No expiration date
- ☐ Expires on _____ (date)

I understand that if I no longer wish for this Personal Representative designation to be in effect, I must deliver notice of revocation in writing to **Mascoma Community Healthcare**. I also understand that it is my responsibility to notify my designee that I have revoked his or her access to my protected health information.

_____ _____

Patient's Name Date

_____ _____

Signature of Patient or Legal Guardian Printed Legal Guardian's Name If Applicable

Mascoma Community Health Center
Patient Rights and Responsibilities

We recognize that health care can be confusing at times, and we want to be transparent when it comes to your rights and responsibilities as a patient at Mascoma Community Health Center.

Your Rights:

1. To choose or change his/ her Primary Care Provider (PCP) as desired. We respect your right to obtain care from another provider, get a second opinion, or seek specialty care.
2. To have accessible, impartial, considerate, and respectful care within the capacity of the facility, regardless of age, race, creed, color, sex, sexual orientation, religion, disability, national origin, or source of payment.
3. To speak with and be examined in private by the provider or clinical assistant.
4. To be treated in a caring, polite, and professional way. This philosophy extends into the right to receive care and services in a safe environment that does not involve abuse, neglect, or exploitation. Patients have the right to report any allegations to management for investigation.
5. To receive information that is appropriate to his/ her age, reading comprehension, and preferred language that will allow them to understand and be part of the care plan. Patients have the right to use and access assistive devices such as an interpreter services, as needed.
6. To know the names of healthcare staff that are taking care of them and what role this person has in the care team. This also applies to care given by students or other people in training.
7. To be informed there is a charge for services and the availability of any discounts or financial assistant programs. Patients also have the right to request an itemized bill or explanation of charges.
8. To receive the necessary information to make informed care decisions. Information shall include, at a minimum, an explanation of recommended procedures or treatments, any value and risks, as well as alternatives to treatment including non-treatment. Patients have the right to refuse any procedure or treatment.
9. The patient/ family/ guardian has the right to inform us when they are unsatisfied with the care and services they received or when we did not meet their expectation. If feedback is received, it will not affect the patient's quality of or access to care in the future. If the patient submits feedback that cannot be resolved by the provider, the care team, or any other staff member, patient may contact a member of Management.
10. To expect a prompt response to questions and/ or requests for information.
11. To have all records pertaining to treatment kept private and confidential, except when necessary to coordinate the referral of care, third party payments, and situations otherwise mandated by law.
12. To review their medical record and to obtain a copy for a reasonable fee, if applicable. Patients also have the right to request a review or amendment of the information therein.
13. To sign Advanced Directives and/ or Designation or Representative, which tells MCHC how that patient wants to be treated and who they want to make decisions on their behalf if they cannot speak for themselves.
14. To be informed of and consent to any recording, filming, or photography used for purposes other than identification, diagnosis, or treatment.

Your Responsibilities:

1. To be honest and tell the provider about current and past illnesses, hospitalizations, medications, and other matters relating to your health history that may influence the treatment plan. Also, reporting any sudden changes in your health.
2. To let staff, know if you do not understand or are unclear of the care plan or if you feel you cannot maintain or complete the care plan goals.
3. To be respectful of the provider's time and that of the other patients by focusing on the main health problem first. If time allows, other concerns may be addressed.
4. To notify staff in advance if you are unable to keep a scheduled appointment.
5. To know there may be negative outcomes if you refuse treatment(s) or do not follow the established care plan.
6. To submit a prompt payment for all services rendered, either through a third-party payer or by personal payment, and to know of any limitations set by your insurance coverage that may result in an unexpected payment, for items not covered, such as a second opinion, consultation, or diagnostic tests.
7. To refrain from bringing any weapon(s) into the practice.
8. To be respectful of the privacy and rights of others, including other patients and healthcare staff.
9. To be responsible for any items brought into the building, including purses, medications, etc.
10. To adhere to our NO SMOKING rules, which applies to the building and grounds, including the parking area.
11. To sign that you have received and understand Mascoma's Consent to Treat which includes the Notice of Privacy Practices.
12. To appoint a family member or designee to be part of your treatment team if you are confused or unable to communicate with staff. This may be done by inviting them to join you in the appointment, or through a written authorization such as an Advance Directive.

I have read the above listed Patient Rights and Responsibilities. I have had an opportunity to ask questions for clarification and understand my responsibility with regard to patient rights. I agree to accept the full responsibility as described above.

_____	_____	_____
Patient Name (Print)	Patient Name (Signature)	Date