Dental New Patient Intake Paperwork

MASCOMA
COMMUNITY
HEALTH CENTER

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!

There are six signature Lines to be signed before emailing. Once complete, save on your computer, attach to an email and email to dentalrecords@mascomahealth.org

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 ☐ Unknown ☐ Widowed ☐ Single ☐ 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: delta dental _____

Policy Number: _____

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

TDo you have a secondary insurance? ☐ Yes ☐ No If yes:

Responsible Party - Who is 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)? ____

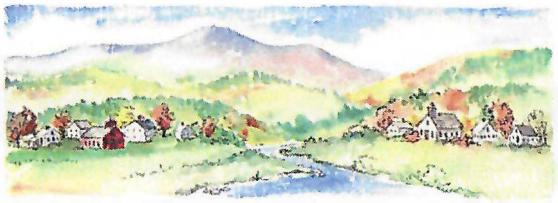
Yearly Household Income: ☐ Less than $22,340 ☐ $22,341 to $30,260 ☐ $30,261 to $38,180
☐ $38,181 to $46,100 ☐ $46,101 to $54,020 ☐ $54,021 to $61,941 or more ☐ Refuse to Report

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 Sign by typing name in 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

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

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, conti ed.

Medications

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

Medication	Dose	Directions
scotch		

Allergies/Intolerances

Allergen	Reaction

Surgeries

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

Date	Surgery	Hospital

'Hospit liz tion

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:

☐ All MEDICAL ☐ All DENTAL

☐ Only those items which are pertinent to this referral

☐ 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): O Only documents from to ☐ All dates

Reason for the 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 CommunityHealthcare 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 that I have the 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) Sign by typing in name | (Printed Name) | (Relationship to Patient if Representative) | (Date)

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