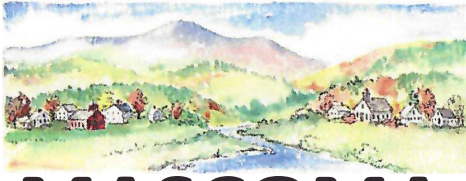


Dental New Patient Intake Paperwork



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 QWork
Secondary Phone: _____ Home Mobile QWork
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: _____

Policy Number: _____

Insurance Type: Private Medicare Medicare Advantage Medicaid Tricare

Do 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 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/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)? _____

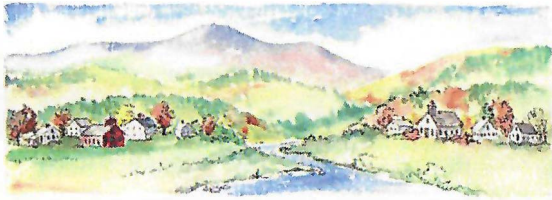
Yearly Household Income: Less than \$22,340 \$22,341 to \$30,260 \$30,261 to \$38,180
 \$38,181 to \$46,100 \$46,101 to \$54,020 \$54,021 to \$61,941 or more Refuse to Report

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? Q Yes Q No

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

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

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

- | | | |
|--|--|--|
| <input type="checkbox"/> Bleeding or Sore Gums | <input type="checkbox"/> Clenching or grinding | <input type="checkbox"/> Shifting of teeth |
| <input type="checkbox"/> Unpleasant taste or bad breath | <input type="checkbox"/> Sensitivity to hot | <input type="checkbox"/> Change in bite |
| <input type="checkbox"/> Burning of tongue or lips | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Dry mouth |
| <input type="checkbox"/> Frequent blisters on lips or in mouth | <input type="checkbox"/> Sensitivity to sweet | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Swelling or lumps in mouth | <input type="checkbox"/> Sensitivity to biting | <input type="checkbox"/> Loose Teeth |
| <input type="checkbox"/> Clicking or popping of jaw | <input type="checkbox"/> History of locked jaw | <input type="checkbox"/> Food impaction |

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

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

If yes, please explain: _____

Are you pregnant or currently breastfeeding? Q Yes Q No

Have you ever taken Bisphosphonate drugs or drugs for bone density or osteoporosis? Q Yes Q No

Have you ever been told to premedicate with antibiotics before dental procedures? Q Yes Q No

Have you ever had head and/or neck radiation or chemotherapy? Q Yes Q No

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

Are you currently taking any corticosteroid medications? Q Yes Q No

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

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

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

Do you drink alcohol? Q Yes Q 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

Allergies/Intolerances

Allergen	Reaction

Surgeries

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

Date	Surgery	Hospital

Hospitalization

Date	Reason	Hospital

Medical History (Check all that apply)

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