Patient Registration Form

Welcome to Community Dental Care!

FOR OFFICE USE ONLY
☐ MINOR (under 18)
☐ ADULT

PATIENT INFORMATION

Name: ____ **Date of Birth:** ____/____/______
Last First Middle Initial

Address: ____
Street/Apt. # City State Zip Code

Telephone: Home: __________________ Cell: __________________ Work: __________________

Email: ____ **Gender:** ☐ Male ☐ Female ☐ Other ________

Preferred Method of Contact (*check one*): Home ☐ Cell ☐ Work ☐ Email ☐ (**Insurance Required:** Male/Female)

Please Check the correct option(s) below:

Language	☐ English ☐ Other: specify_______________
Race	☐ Asian ☐ AfricanAmerican ☐ Caucasian ☐ NativeAmerican ☐ Hawaiian ☐ PacificIslander ☐ Other:______
Ethnicity	☐ Hispanic ☐ Hmong ☐ Karen ☐ Somali ☐ Other: Specify_______________
Status	☐ Child ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Referred By	☐ Family ☐ Friend ☐ Interpreter ☐ Insurance Plan ☐ County Worker ☐ Dental Office ☐ Hospital ☐ School ☐ Phone Book ☐ Walk-In ☐ Internet ☐ Flyer ☐ Community Event ☐ Portico Healthnet ☐ Other: _________

GUARDIAN INFORMATION- *For Minors (under 18) or if the patient cannot consent to their own treatment*

Guardian (1) Name: __________________________
Date of Birth: ____/____/______
Telephone: H/C/W __________________________
Address (If different from Patient):
____
Relation: __________________________________
Father/Mother/Legal Guardian

Guardian (2) Name: __________________________
Date of Birth: ___/___/_____
Telephone: H/C/W __________________________
Address (If different from Patient):
____
Relation: __________________________________
Father/Mother/Legal Guardian

EMERGENCY CONTACT- *In case of a medical emergency, who may we contact?*
Name: ______________________________ **Phone:** ____________________ **Relation:** ___________________
Last First

INSURANCE INFORMATION

Primary Insurance
Policy Holder Information:
Full Name: _________________________________
Date of Birth: ____/____/______
Plan Name: _________________________________
ID: __________________ **Group#:** ______________
Service Phone #: ____________________________
Claims Address:
____

Secondary Insurance – (if applicable)
Policy Holder Information:
Full Name: _________________________________
Date of Birth: ____/____/______
Plan Name: _________________________________
ID: __________________ **Group#:** ______________
Service Phone #: ____________________________
Claims Address:
____

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I authorize the treating dentist to perform diagnostic procedures and treatment as indicated for my (or my child's) proper dental care.
I authorize release of any information concerning my (or my child's) heath care, advice, and treatment to another dentist.
I understand that dental treatment recommendations are subject to change as treatment progresses due to unforeseen complexities.
I certify that all of the above information is true and correct to the best of my knowledge.

Signature: ____ **Date:** ________________________
Patient/Parent/Legal Guardian

Interpreter/Witness Name: ____ **Phone:** ____________________

COMMUNITY DENTAL CARE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name ____

Address ____

Telephone ___________________________________

TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out our treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and other important matters about your protected health information. A copy of our Notice of Privacy Practices accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices which will contain the changes. These changes may apply to any of your protected health information that we maintain.

You may obtain another copy of our Notice of Privacy Practices, including revisions, at any time by contacting: **Privacy Officer**

Telephone: 651-925-8400 Fax: 651-925-8439
1670 Beam Avenue
Maplewood, Minnesota 55109

Consent Does Not Expire after One Year. By signing this Consent form, I am explicitly giving informed consent for the release of health records and health information for the purposes listed herein and that this Consent does not expire after one year for 1) the release of health records to a provider who is being advised or consulted with in connection with the releasing provider's current treatment of myself; or, 2) the release of health records to an accident and health insurer, health service plan corporation, health maintenance organization, or third-party administrator for purpose of payment of claims, fraud investigation, or quality of care review and studies.
Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Privacy Officer listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent. You may obtain a revocation of consent form upon request.

For Telephone, Text, Email Communications

I consent to the following: This Dental Practice or its service provider may contact me to provide health care information such as appointment reminders about treatment, payment, my insurance, my account, using prerecorded or artificial prerecorded voice or telephone equipment that may be capable of automatic dialing.

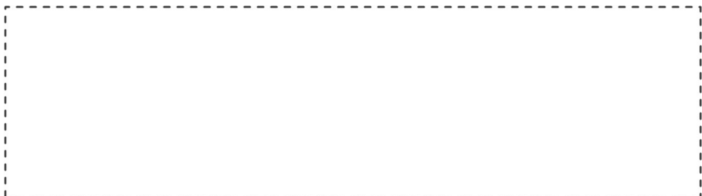
SIGNATURE
I have received a copy of this practice's Notice of Privacy Practices and have had the full opportunity to read and consider the contents of this Consent form. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature____Date:___________________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative Name:____
NOTE: A parent is considered a Personal Representative for a minor under the HIPAA Privacy Regulations.

Relationship to Patient:____



Medical History

Physician's Name: ______________________________________

Location: ______________________________________

Pharmacy: ______________________________________

1. Do you see a physician for yearly check ups? .... ☐ Yes ☐ No
2. Do you see a physician to manage a medical condition(s)? ☐ Yes ☐ No
3. Do you have any of the following:
   ☐ Active tuberculosis ☐ Coughing up blood
   ☐ Been exposed to anyone with active tuberculosis

If you answered Yes to Question 3, please immediately notify receptionist

4. Have you had a total joint replacement? .... ☐ Yes ☐ No
   Date: __________ Any complications? ________________________
   Were you told that you needed premedication? .... ☐ Yes ☐ No
5. Do you need pre-antibiotics for any of the following:
   ☐ Infective endocarditis (infection of heart lining)
   ☐ Artificial heart valve ☐ Congenital heart disease (birth defect in heart)
6. Have you had any surgeries
   or been hospitalized in the past 5 years? .... ☐ Yes ☐ No
   If yes, explain ______________________________________
   ____

* 7. **Medications**: Are you taking any medications? .... ☐ Yes ☐ No
   Please list all your medications in the space provided to the right. →
   Do you take any of the following medication types? (check all that apply)
   ☐ Bisphosphonates (for osteoporosis, bones)
   ☐ Nitroglycerin ☐ Blood thinners (Coumadin, etc.) ☐ Steroids
8. **Allergies:** Are you allergic to or have you had a reaction to: ☐ No allergies
   ☐ Penicillin ☐ Other antibiotics ☐ Local anesthetics ☐ Aspirin
   ☐ Sulfa Drugs ☐ Latex ☐ Other Allergies____________________
   Reaction(s): ______________________________________
9. Have you been vaccinated for hepatitis B?........................... ☐ Yes ☐ No
10. Have you ever had any of the following?

Medications and Additional Information

CARDIOVASCULAR
☐ High blood pressure
☐ Low blood pressure
☐ Heart attack
☐ Cardiovascular disease
☐ Congestive heart failure
☐ Angina (heart/chest pain)
☐ Heart defect
☐ Heart murmur
☐ Rheumatic fever
☐ Irregular heartbeat
☐ Pacemaker

BLOOD
☐ Hemophilia
☐ Anemia
☐ Bleeding disorders

MUSCULOSKELETAL
☐ Arthritis
☐ Osteoporosis

SKIN
☐ Bleed/bruise easily
☐ Slow healing
☐ History of skin cancer

RESPIRATORY
☐ Asthma
☐ COPD
☐ Sleep apnea/snoring
☐ Bronchitis
☐ Emphysema
☐ Cystic fibrosis

NEUROLOGICAL
☐ Brain injury
☐ Stroke
☐ Epilepsy/seizures

ENDOCRINE
☐ Thyroid problems
☐ Diabetes (Type I or II)
☐ Hormone problems

GASTROINTESTINAL
☐ Acid reflux/heartburn
☐ Eating disorder
☐ Gastrointestinal disease
☐ Liver problems
☐ Hepatitis (A, B, or C)

URINARY
☐ Kidney problems
☐ Dialysis

PSYCHIATRIC/ DEVELOPMENTAL
☐ Anxiety
☐ Depression
☐ Other mental health disorder
☐ Learning disability
☐ Developmental delay
☐ Individual Education Plan
☐ ADD/ADHD

OTHER
☐ Cancer/Tumor
☐ Head and neck radiation
☐ Organ transplant
☐ Autoimmune disease
☐ Lupus
☐ Sjogren's Syndrome
☐ Chronic pain
☐ Fibromyalgia
☐ HIV or AIDS
☐ Sexually transmitted infection
☐ History of trauma/abuse
☐ Eyesight problem
☐ Hearing loss
☐ Memory problems

Please list any additional diagnoses or medical problems in the box above.

11. Do you currently
    ☐ Smoke/use tobacco/e-cigs ☐ Use recreational drugs
    ☐ Drink alcohol ☐ Use marijuana ☐ Chew betel nut
12. Are you a recovering alcoholic? ....☐ Yes ☐ No
13. Do you have a history of substance abuse?...☐ Yes ☐ No

Women

1. Are you taking birth control? .... ☐ Yes ☐ No
2. Are you pregnant? ... ☐ Yes, Due Date:_____________ ☐ No
3. Are you nursing/breast feeding?.........................☐ Yes ☐ No

Dental History

1. Do you have any fever blisters, ulcers, or sores on your lips or mouth? …………. Yes No
2. Do your gums bleed when you brush or floss? …………………………………………… Yes No
3. Have you worn braces for straightening your teeth? …………………………………… Yes No
4. Do you have partials or dentures? …………………………………………………………… Yes No
5. Do dental treatments cause you concern or worry? ……………………………………… Yes No
6. Do you clench or grind your teeth? ………………………………………………………….. Yes No
7. Do you have TMD or pain in your jaw joint (TMJ)? ………………………………………. Yes No
8. Do you have clicking, popping, or pain in the jaw? ……………………………………. Yes No
   If so, what side? Right Left Both
9. Do you have earaches or neck pain? ………………………………………………………. Yes No
10. Have you ever had a serious injury to your head or mouth? ……………………….. Yes No

11. Date of your last dental exam: ________________

12. Date of last dental x-rays: __________________

13. How often do you brush your teeth? __________________

14. How often do you floss? __________________

15. What is your sugar intake? …………………………………………………………

 High
- Drinks 1 or more sweeten beverage each day
  - Soda, chocolate milk, juice, sports/energy drinks, coffee/tea with sugar, etc…
  - Children who go to bed/nap with bottle or sippy cup containing milk or sugared beverage
- Two or more snacks/day between meals of processed or sugar-added foods.
  - Ex: Crackers, chips, cereal, candy, cookies, sugared gum, desserts, yogurt/fruit with added sugar etc…

 Medium
- Drinks 1 or more sweeten beverage each week
  - Soda, chocolate milk, juice, sports/energy drinks, coffee/tea with sugar, etc…
- One snack/day between meals of processed or sugar-added foods.
  - Ex: Crackers, chips, cereal, candy, cookies, sugared gum, desserts, yogurt/fruit with added sugar etc…

 Low
- Drinks little to no sweetened beverages (soda, chocolate milk, juice, sports/energy drinks, etc…)
- Minimal snacks between meals of processed food or foods with sugar added.

Patient/parent/guardian signature ____ Date _____________

Interpreter/witness signature ____ Date _____________

COMMUNITY DENTAL CARE BROKEN APPOINTMENT PROTOCOL

We are a community dental clinic that strives to serve our patients and provide accessible dental care to those in need. We accept a wide variety of insurances, including all Minnesota State Insurance programs. Due to the overwhelming need for dental care, we have a long list of patients waiting to be seen and become patients with us. We have a strict attendance policy to ensure provider time is not unproductive to help other patients.

Please read and sign below to acknowledge you understand and will adhere to our policies.

- I am aware that if I miss 2 appointments within 12 months, I will no longer be able to reserve an appointment time until I've honored two walk-in and wait visits.

  A walk-in and wait visit means coming to the clinic and waiting to be seen. If after 2-3 hours of waiting and you still haven't been called back, you may leave after checking in with the receptionist. This needs to be done twice before you can resume scheduling appointments. After this you may schedule one appointment at a time.

- I am aware that if I cancel an appointment without a 24-hour notice all further scheduled appointments will be cancelled.

- I am aware that I may not be seen if I arrive after my scheduled appointment time.

Patient/LG Signature: ______________________________

Our broken appointment protocol applies to all missed appointments and cancellations without a 24-hour notice

Community Dental Care

PATIENT INFORMATION DISCLOSURE CONSENT

A. Family and Friends. It is the office policy of Community Dental Care not to release confidential medical and health information regarding your treatment to family members or friends, excepts for 1) parent/legal guardian; 2) other persons authorized by the patient 3) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment); 4) in emergency situations, or 5) as otherwise permitted by the Health Insurance Portability and Accountability Act (HIPAA)

If you anticipate that you will need or want your medical or health information to be provided to family members, friends, or caretakers/babysitters, please sign below so that we can release that information to that person. If you do not want any of your medical or health information provided to a family member or friend, please circle the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. If you wish to add names later on, please confirm this in writing.

You may cancel this authorization to the extent allowed by law. If you do, you understand that the doctor or Practice may have already released information about you after you gave permission. You understand that cancelling this authorization would not prohibit any release of information by the Practice in reliance on your original authorization.

If you wish to cancel or change this agreement, please issue a letter in writing to Community Dental Care.

Please indicate the name of the individual(s) below that you wish to have information disclosed to.

		Health Care Information	Financial Information
Spouse	________________	Yes/No	Yes/No
Parent	________________	Yes/No	Yes/No
Other	________________	Yes/No	Yes/No

Below are different contact methods that you wish to be contacted by regarding family appointment reminder(s), health care and financial information. By initialing below, you are authorizing us to contact you by the preferred method(s).

__________ Phone call

__________ Email

__________ Permission to leave HIPAA compliant voicemail, protecting patient's health information

__________ Text message (opt in for text message reminders regarding upcoming appointments)

__________ Permission to leave detailed voicemail regarding health care and financial information

B. Alternative Communications. You are also entitled to specify alternative, reasonable means of communication, if you do not want to be contacted in a certain way.

I hereby request the following means of contact only________________________________

PRINTED NAME: ________________________________

Patient/Parent/Guardian Signature: ________________________________

Date: ________________________