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:
____

****

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

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

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

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 _____________

Behavior Management Informed Consent

To the parent or guardian of

Child's Name _Birth date_

Most children are usually cooperative during dental procedures, however sometimes they are frightened by the sights and sounds of the equipment or the unknown experience. This is especially true for children younger than three years, but it can also occur with some older children.

To help calm your child the dentist will use **positive reinforcement** (praise and compliments), **voice control** (authoritative tone of voice to set limits and discourage unsafe behavior), **distraction** (stories and conversation to take the child's mind off of the procedure), and **Tell-Show-Do** (simple explanation of the dental procedure and demonstration on the child's fingers before proceeding to the mouth).

Sometimes other behavior management techniques may be necessary in order to treat your child safely:	Do you permit the doctor to use this technique?
• **Mouth Prop** -helps hold the child's mouth open in order for the dentist to have better access and prevents the child from biting down on a working drill. If a child falls asleep during the procedure, the Mouth Prop will allow the dentist to continue working without waking the child up.	☐**Yes** ☐**No**
• **PedoBurrito™** -functions as a dental chair "seat belt" to stabilize and protect the child. A strong Velcro wrap and cushion secures the child in the proper position. The child's arms, legs, and bottom are secured so that he/she cannot be injured by grabbing or kicking the equipment, the assistant, the parents, or the doctor.	☐**Yes** ☐**No**
• **Holding Assistant-**helps secure the child and position him/her on the dental chair. In addition, the holding assistant can comfort, massage, and soothe the child. The holding assistant may be a dental assistant or one of the child's parents.	☐**Yes** ☐**No**
• **Nitrous Oxide Informed Consent -** Nitrous oxide helps a child to relax and helps control the gag reflex. The child breathes a blend of two gases (oxygen and nitrous oxide) through a mask placed over the nose. During this time the child is relaxed but fully conscious. Nitrous oxide is a mild sedative that is non-addictive and quickly expelled from the body by normal breathing. The use of, alternatives to, and the benefits and risks of nitrous oxide for dental treatment have been explained to me and I authorize the use of nitrous oxide for my child's treatment.	☐**Yes** ☐**No**

Note: If you do not give permission for use of the above behavior management techniques, the dentist may choose not to treat your child. You have the option to take your child to another clinic that may offer sedation or general anesthesia. Without treatment, any cavities your child has will probably become worse and be more difficult or more costly to treat.

Parent or Guardian _Date_ _Interpreter or witness_ _Date_ _Doctor_

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