PATIENT INTAKE FORM

Community Dental

PATIENT INFORMATION

Last Name:	First Name:		MI:		
Preferred Name:	Date of Birth:		Social Security Number:		
Sex: ❑Male ❑Female ❑Declined to Answer ❑ Other: Preferred Pronoun: (optional)					
Primary Language: ❑English ❑Spanish ❑French ❑Arabic ❑Russian ❑Somalian ❑ASL ❑Other:					
Marital Status: ❑Single ❑Married ❑Widowed ❑Divorced ❑Separated ❑Child ❑Other					
Race/Ethnicity: ❑American Indian/Alaskan Native ❑Asian ❑Black/African American ❑Native Hawaiian/Other Pacific Islander ❑White/Caucasian ❑Other Race ❑Two or More Races ❑African ❑Hispanic/Latino ❑Declined to Answer					
Home Address:			| Mailing Address:		❑Same as Home Address
City:	State:	Zip Code:	| City:	State:	Zip Code:
Mobile Phone:			| Secondary Phone:		
Email Address:					
Emergency Contact:			Emergency Phone #:		
Do you require interpreter services? ❑YES ❑NO If yes, please specify language:					
Are you able to legally sign to consent for treatment? [Only for patients over 18 years old] **❑YES ❑NO**					

GUARDIANSHIP

Please fill this section out if the patient being treated is under the age of 18 and/or not able to consent for treatment on their own. It is the sole responsibility of the patient's parent or guardian to keep the below information updated. Any changes to the consent must be in written form to remain valid. Legal documentation must be presented and will be copied for patient's record.

First Name:		Last Name:	
Relationship to Patient:		Date of Birth:	
Street Address:			
City:	State:	Zip Code:	
Primary Phone:		Secondary Phone:	
Who is additionally authorized to consent for treatment for patient?			
First Name:		Last Name:	
Relationship to Patient:		Date of Birth:	
Street Address:			
City:	State:	Zip Code:	
Primary Phone:		Secondary Phone:	

If you would like to add additional people this list, the front desk can provide an addendum for you.

*******CONSENT FOR SEDATION, AND/OR EXTRACTION(S) MUST BE SIGNED BY PARENT OR GUARDIAN, NO EXCEPTIONS*******

Treatment to include, but not limited to exams, x-rays, extractions, fillings, root canal therapy, routine, or periodontal therapy cleanings. If the patient presents for treatment and the above parent/guardian is not present, the appointment may need to be rescheduled.

I UNDERSTAND THE ABOVE LISTED PEOPLE ARE AUTHORIZED TO SIGN THE CONSENT FOR TREATMENT AND ARE WILLING TO ADHERE TO POST TREATMENT CARE RECOMMENDATIONS.

SIGN HERE

_____ _____

PATIENT | PARENT | LEGAL GUARDIAN SIGNATURE **DATE**

First Name:	MI:	Last Name:

Insurance

Subscriber Information		
First Name:	MI: Last Name:	
Employer Name:		
Insurance Company:		Insurance Phone Number:
Subscriber ID/Policy Number:		Group/Contract Number:
Date of Birth:		SSN:
Patient Relationship to Subscriber: ❑Child ❑Disabled Dependent ❑Spouse ❑Self ❑Other		
Is Patient covered under MaineCare? ❑**YES** ❑**NO**		**MaineCare ID#:**

MAINECARE DENTAL SERVICES BENEFIT

MaineCare dental benefits provided to all children and adults 21 years of age and older may be limited to:

- Diagnostic services, such as oral evaluations and x-rays
- Preventive services, such as cleanings, fluoride, and tobacco and substance use counseling severely
- Restorative services, such as fillings and crowns
- Endodontic services, such as root canals
- Periodontic services, such as various gum surgeries and cleanings that occur below the gum
- Complete, partial, and immediate dentures and denture repairs
- Complete, partial, and immediate dentures and denture repairs
- Oral surgeries, such as tooth extractions and removal of tumors and lesions
- Adjunctive services, such as sedation and night guards
- Any dental procedure or service (including above listed procedure) may not be covered if the patient's MaineCare eligibility has lapsed, or the coverage type does not include dental benefits.

By signing this form, I acknowledge I have read and understand the limitations of my MaineCare benefit. I understand payment is due at time of service and I am responsible for all non MaineCare covered services. Please note: The services you receive today may not be covered by your MaineCare benefit. If the service is not a covered benefit, you will be responsible for payment in full for the services provided.

_____ _____

PATIENT | PARENT | LEGAL GUARDIAN SIGNATURE **DATE**

SLIDING FEE APPLICATION

Community Dental has limited assistance available to **patients and families who are NOT covered by dental insurance.** If you would like to be considered for reduced fees, please provide us with your household income. **Proof of income is required** and must be updated each new calendar year to receive reduced fees.

TOTAL MONTHLY WAGES FOR ALL MEMBERS OF THE FAMILY (TANF, SSDI, Pension, Retirement, Child Support, Alimony, Unemployment, Workman's Comp, etc.): **$**

PLEASE LIST ALL MEMBERS OF THE HOUSEHOLD, FIRST NAME, LAST NAME AND AGE.

NAME	AGE	NAME	AGE

I understand that Community dental is funded by limited public and private sources and that approval of my application does not obligate Community Dental to discount my care if funds are not available. I certify that this is true and accurate statement of my income at this date. I am enclosing a copy of my check stub, W-2, or other verification of income.

_____ _____

PATIENT | PARENT | LEGAL GUARDIAN SIGNATURE **DATE**

First Name:	MI:	Last Name:

MEDICAL HISTORY

Reason for today's visit?

Dental History: Please Mark Response

Date of Last Dental Visit: ❑**In Last 6 months** ❑**6 months - 1 year** ❑**1-3 years** ❑**Greater than 4 years** ❑**Never Other:**_____

Date of Last Dental X-ray: ❑**In Last 6 months** ❑**6 months - 1 year** ❑**1-3 years** ❑**Greater than 4 years** ❑**Never Other:**_____

How often do you brush? How often do you floss?

✓ Please Mark Response	YES	NO	DK	✓ Please Mark Response	YES	NO	DK
Treated for periodontal (gum) disease?				Marijuana Use?			
Had Novocain or another local anesthetic?				Mouth Sores			
Are you currently wearing Dentures?				Broken/Loose Teeth			
If yes: Age of dentures:				Pain In Jaw (TMJ) Grind/Clench			
Use Tobacco Products (cigarette, chew, dip)				Sensitive Teeth			
if yes, how often?				Swollen/Bleeding Gums			

Preferred Pharmacy Name:

Phone Number:

Street: Zip: City: State:

Medical Information

Are you under the care of a physician? ❑**YES** ❑**NO** If yes, for what?

Physician Name:

Physician Phone Number: Fax Number:

Street Address:

City: State: Zip:

Last Date of Physical:

Has a physician or previous dentist recommended that you take antibiotics prior to dental treatment?* ❑**YES** ❑**NO** ❑**DK**

Allergies **Are you allergic to or have you had a reaction to:**

✓ Please Mark Response	YES	NO	DK	If yes, please specify:
Local Anesthetic				
Aspirin				
Penicillin or other antibiotics				
Barbiturates/sedatives/sleeping pills				
Sulfa				
Codeine				
Other				

Women Patients Only:	YES	NO	DK
Are you currently pregnant?			
How many weeks?			
Are you Nursing?			
Are you taking any birth control prescriptions?			

*NOTE Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

First Name:	MI:	Last Name:

Are you taking or scheduled to begin taking an antiresorptive therapies (Example: Fosamax, Actonel, Atelvia, Boniva, Reclast, or Prolia) for Osteoporosis or Paget's Disease? ❑**YES** ❑**NO** ❑**DK** If yes, please indicate the date treatment began:

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (Example: Aredia, Zometa or Xgeva) for bone pain, hypercalcemia or skeletal complications resulting from Paget's Disease, multiple myeloma, or metastatic cancer? ❑**YES** ❑**NO** ❑**DK** If yes, please indicate the date treatment began:

Current Patient: Have you had any changes to your Health History since the last time you were seen at Community Dental?
❑**YES** ❑**NO** ❑**DK** If yes, please indicate the changes below:

New Patient: Please fill out the below Health History

Health History: Please Complete to The Best of Your Ability With YES, NO or DK (Do Not Know)

✓ **Please Mark Response**	**YES**	**NO**	**DK**	✓ **Please Mark Response**	**YES**	**NO**	**DK**
Tuberculosis				Chemotherapy/ Radiation Therapy			
Cardiovascular Disease				Chronic Pain			
Angina				Diabetes Type 1; last A1C:			
Arteriosclerosis				Diabetes Type 2; last A1C:			
Congestive Heart Failure				Eating Disorder			
Damaged Heart valves				Gastrointestinal Disease			
Heart Attack				Ulcers			
Heart Murmur				Thyroid problems			
Low Blood Pressure | High Blood Pressure				Cholesterol			
Endocarditis				Stroke			
Other Congenital Heart Defects				Glaucoma			
Mitral Valve Prolapse				Hepatitis; Type:			
Pacemaker				Epilepsy			
Rheumatic Heart Disease				Fainting or Dizzy Spells			
Anemia				Neurological Disorder			
Blood Transfusion, date:				Mental Health Disorder			
Blood Disorder; Type:				Recurrent Infections			
AIDS/HIV Infection				Kidney Problems			
Arthritis				Night Sweats			
Autoimmune Disease				Osteoporosis			
Rheumatoid Arthritis				Persistent swollen glands in neck			
Systemic Lupus Erythematosus				Severe Headaches/Migraines			
Asthma				Severe or rapid weight loss			
Bronchitis				Sexually Transmitted Disease			
Emphysema				Alcoholism			
Sinus Trouble				Drug Addiction			
Cancer; Type:				Joint Replacement			

Do you have any disease, condition, or problem not listed above that you think I should know about? ❑**YES** ❑**NO** ❑**DK**
If yes, please explain:

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because errors or omissions that I may have made in the completion of this form.

PATIENT | PARENT | LEGAL GUARDIAN SIGNATURE **DATE**

First Name:	MI:	Last Name:

MEDICATION LIST

Current Patient: Have you had any changes to your Medication List since the last time you were seen at Community Dental?

❑**YES** ❑**NO** ❑**DK** If yes, please indicate the changes below:

New Patient: Please list all medications you are currently taking, both prescription and over the counter (vitamins, pain medication, herbal supplements).

MEDICATION	DOSAGE	REASON FOR TAKING

I acknowledge the above medications and dosages are accurate and true to the best of my knowledge. I am aware that if any of my medications/ dosage change, it is my responsibility to inform my provider(s).

SIGN HERE

_____ _____

PATIENT | PARENT | LEGAL GUARDIAN SIGNATURE **DATE**

First Name:	MI:	Last Name:

PATIENT SIGNATURE SECTION

Patient Signatures Release of Information to Insurers and Assignment of Benefits (must be signed by all patients with insurance and those who expect to obtain insurance) To the extent permitted by law, I consent to my practices (or their designees) use and disclosure of my Protected Health Information to carry out payment activities in connection with my insurance claim. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize and direct payment to my practice of the dental benefits otherwise payable to me.

Signature: _____ Date: _____

(If patient is a minor or disabled the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party section).

Payment, Insurance and Financial Arrangement Policies (signed by patient, parent, guardian, or attorney-in-fact) By signing below, I acknowledge that I received the Financial Policies form and agree to abide by such policies.

Signature: _____ Date: _____

(If patient is a minor or disabled the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party section).

Notice of Privacy Practices (signed by patient, parent, guardian, or attorney-in-fact) By signing below, I acknowledge that I have read the Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Signature: _____ Date: _____

(If patient is a minor or disabled the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party section).

Authorization for Release of Health Records to External Parties (This section is optional)
I authorize the disclosure of information from my treatment records to:
Name of Recipient: _____
Relationship to the Patient: _____
I give authorization to disclose the following information: Please Mark Response
❑All treatment information
❑Specifically related to these treatment dates
Starting Date: _____ End Date: _____

Signature: _____ Date: _____

(If patient is a minor or disabled the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party section).

Consent to Obtain Patient Medication History (This section is optional) To the extent permitted by applicable law, I authorize this dental practice (or their designees) to collect information about my prescription history from my pharmacy and insurers (as applicable) and give my pharmacy and insurers permission to disclose such information. This includes prescription information related to medicines to treat AIDS/ HIV and medicines used to treat mental health issues.

Signature: _____ Date: _____

(If patient is a minor or disabled the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party section).

COMMUNITY DENTAL POLICIES

Privacy Policy

Our Legal Duty Community Dental ("we," "our," "us"), like all other medical and dental practices, is required by applicable federal and state laws to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice went into effect October 20, 2014 with the latest revision May 4, 2020, and will remain in effect until modified or replaced. We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request. You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us according to the means outlined in this notice.

Uses and Disclosures of Health Information
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment
We may use or disclose your health information to a physician/dentist, dental auxiliaries, students and other healthcare providers providing treatment to you.

Payment
We may use and disclose your health information to obtain payment for services we provide to you. Payment is due at time service(s) are rendered.

Insurance
We may use and disclose your Protected Health Information to carry out payment activities in connection with your insurance claim. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. As a courtesy to our patients, we will attempt to file dental claim(s). Should your insurance not make payment for any reason(s), it is the sole responsibility of patient or parent/guardian if patient is a minor or disabled to make payment.

Healthcare Operations:
We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performances, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization
In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends
We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care
We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up prescriptions, dental supplies, X-rays, or other similar forms of health information.

Public Health Activities

- We may use or disclose your health information for public health activities, including disclosures to:
- Prevent or control disease, injury, or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim or abuse, neglect, or domestic violence.

Worker's Compensation
We may disclose your PHI to the extent authorized by and to the extent necessary to comply with the laws, relating to worker's compensation or other similar programs established by law.

Important Broken Appointment Notice
Missed appointments prevent patients from getting the care they need. Community Dental may restrict patients from scheduling appointments if they have broken an appointment. An appointment is considered to have been broken if:

1. The patient fails to appear for the appointment, or
2. The patient arrives too late for a scheduled appointment, or
3. The patient cancels an appointment with **less than 24 hours notice.**

Marketing Health-Related Services
We may use Patient Information internally to offer goods and services we believe may be of interest. We may use Patient Information to contact you to inquire or survey about the Patient experience at the location(s) visited and the prospect of future services or improvements needed to continue as your services provider. We may also create and use aggregate Patient Information that is not personally identifiable to understand more about the common traits and interests of our Patients.
We may utilize one or more third-party service providers to send email or other communications to you on our behalf, including Patient satisfaction surveys. These service providers are prohibited from using your email address or other contact information for any purpose other than to send communications on our behalf.
It is our intention to only send email communications that would be useful to you and that you want to receive. When you provide us with your email address as part of the registration or appointment setting process, we will place you on our list of patients to receive informational and promotional emails. In addition, patients and visitors to our website are given the opportunity to "opt-in" to receive electronic promotional communications by selecting the option to receive promotional emails from us on our website.
Each time you receive a promotional email, you will be provided the choice to "opt-out" of future emails by following the instructions provided in the email, or you can "opt-out" at any time by following the instructions provided.

Cookies
Our website utilizes "cookie" technology. "Cookies" are encrypted strings of text that a website stores on a user's computer. Our website uses cookies throughout the online process to keep together information entered on multiple pages. For example, cookies enable our website to "remember" information provided to us. In addition, cookies are used to:

- Measure usage of various pages on our website to help us make our information more pertinent to your needs and easy for you to access; and
- Provide functionality such, as online appointing, bill paying and other functionalities that we believe would be of interest and value to you.

The two types of cookies that we use are referred to as "session" cookies and "persistent" cookies. Session cookies are temporary and are automatically deleted once you leave our website. Persistent cookies remain on your computer hard drive until you delete them. We do not use cookies to gather any personally identifiable information about you apart from what you voluntarily provide us in your dealings with us. Our cookies do not corrupt or damage your computer, programs, or computer files. You may set your browser to block cookies.

Fundraising
We will not use your health information for fundraising activities without your written consent.

Required by Law
We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect
We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety, or the health or safety of others.

National Security
We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose, to authorized federal officials, health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to a correctional institution or law enforcement official having lawful custody of protected health information of an inmate or patient under certain circumstances.

Appointment Reminders
We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Patient Rights Access
You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. We may charge a fee for producing dental records and X-rays as allowed by law.

Disclosure Accounting
You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions
You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). When you pay in full outside of your insurance plan for services you may request that we restrict this information and not disclose it to your healthcare plan or insurer.

Breach Notification
We will provide you with notification of a breach of unsecured PHI as required by law.

Alternative Communication
You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. This request must be in writing. Your request must specify the alternative means or location and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment
You have the right to request that we amend your health information. This request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice
If you received this notice on our web site or by electronic mail (e-mail), you are also entitled to receive this notice in written form.

Questions and Concerns
If you would like additional information about our privacy practices or have questions, Community Dental's HIPAA Compliance Officer may be reached at **(207) 874-1028, Extension 4004**.
If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or our handling of your response to a request you made to amend or restrict the use or disclosure of your health information, or to have us communicate with you by alternative means or at alternative locations, you may send your concerns to Community Dental, Attn: HIPAA Compliance Officer, 190 Park Ave Portland, ME 04102. You also may submit written concerns to the U.S. Department of Health and Human Services. We will provide you with the address to the U.S. Department of Health and Human Services upon request.
We support your right to maintain the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Community Dental

Helping Maine families smile since 1918.

- PORTLAND -
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Portland, ME 04102
Phone - (207) 874-1028 | Fax (207) 842-2963
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- BIDDEFORD -
57 Barra Road - Suite 3
Biddeford, ME 04005
Phone - (207) 282-1305 | Fax (207) 282-7351
E-Mail - biddeford@communitydentalme.org

- LEWISTON -
177 Main Street
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- FARMINGTON -
131 Franklin Commons - Suite 1
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