MASCOMA COMMUNITY HEALTH CENTER

New Patient Information - DENTAL

We are committed to meeting the needs of our patients. Our entire team wants to make sure your experience at the Health Center is positive, and that you will return when you require our services, again. We strive to offer quality dentistry, while working with our patients to create affordable treatment plans.

Before Your First Visit...

There are a few steps that we ask to be completed before your first appointment. These are:

1. Complete, sign, and return a New Patient Dental Packet to us so that we can enter your information into our electronic health record.

2. The New Patient Dental Packet includes the Release of Information. These are for us to get information about any dental care that you may have had in the past, including X-rays, exams, dental surgery, etc. Please fill these forms out completely, and sign at the bottom, so that we can send them to your previous dental office and get the information BEFORE you come for your first appointment with us.

3. If there is anything in the New Patient Dental Packet that you don't understand, or have a question about, please call us or stop by. We are happy to help with these forms.

At Your First Visit...

This is what to expect at your initial visit at the dental clinic:

4. All new patients must meet with our Dentist for a "comprehensive oral exam." This means that we will look closely at your mouth and teeth to determine how healthy these are, and check out any issues or problems that you may be having.

5. Our Dentist and assistant will also ask questions of you to determine what your past dental care may have been, and verify any records that we have gotten from your prior dentist(s).

6. If you have not had dental X-rays in a while, or, if we were unable to get recent ones from your prior dentist, we will need to take X-rays here, so that we have current films of the state of your mouth/teeth. These are very important in helping the dentist and staff develop a diagnosis and treatment plan for you.
   A TIP ABOUT X-RAYS: In order to get clear X-rays, we ask that you do not wear any jewelry, including necklaces, earrings, nose rings, etc. to your appointment.

PAYING FOR YOUR VISIT...

And some information about billing:

7. We accept cash, credit cards, or insurance plan payment. Please bring any insurance information and insurance cards with the subscriber identification. We accept many insurance plans. It is our policy to bill the insurance companies on your behalf however, any unpaid balances are the patient's responsibility. Please also see payment policy that is attached to your New Dental Patient Packet.

8. If you need financial assistance, please ask our front office staff about our discount, payment plans, or eligibility for the Sliding Fee Scale program.

MASCOMA COMMUNITY HEALTH CENTER

PATIENT REGISTRATION FORM

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 your medical record is complete and up to date. Thank you for helping us to make your health care experience a good one!

Patient Information: Name: (First) ________________(Middle)__________(Last)____________________Suffix(Jr., Sr., etc.)_____

Previous Last Name:________________ Address (Street or PO Box, City, State, Zip):____

Home Phone: (__)____________ Cell Phone: (__)_____________ Work Phone: (__)___________ Email:________________________

Is it OK to leave a message at these numbers: ☐ Yes ☐ No If yes, please select: ☐ Appointment. info only ☐ Appt. & Medical Info How would you like us to communicate with you (check all that apply): ☐ Phone call ☐ Text message ☐ Patient Portal

Date of Birth:__________ Sex: ☐ Male ☐ Female ☐ Unknown ☐ Transgender-Male/Female-To-Male ☐ Transgender-Female/Male-To-Female ☐ Choose not to disclose

Marital Status: ☐ Divorced ☐ Married ☐ Partner ☐ Single ☐ Unknown ☐ Widowed ☐ Legally Separated

Social Security Number _____-_____-_____

Employer Name: ______________________________________ 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 U.S. Veteran? ☐ Yes ☐ No Branch of Military Service _______________ Number of years of service:______

Responsible Party Information (Who is Responsible for Paying the Bill): ☐ Self ☐ Other person (fill in below)

Last Name___________________________________First Name__________________________Middle Name:_______________

Address:____City__________________State___________Zip ___________

SSN_______-____-________DOB:______________ Home Phone:( )______________ Work Phone:( )_____________

Cell Phone: ( )_______________Relationship to Patient:_________________________

Emergency Contact (Fill in if there is someone you want us to contact in the event of an emergency):

Relationship to you: _____________ Is this person your legal guardian: ☐ Yes ☐ No Can we also share your medical information with his person: ☐ Yes ☐ No Contact's Name:________________________ Address:________________________

Home Phone:_________________ Cell Phone:_________________ Work Phone:_________________

Pharmacy Information: Your local pharmacy name:________________________ Location:___________________________

Phone Number:________________ Mail Order Pharmacy Name (if applicable):____

Address:____ Phone Number:__________________

MASCOMA COMMUNITY HEALTH CENTER

PATIENT REGISTRATION FORM

****Prescription History Consent: I hereby give Mascoma Community Healthcare, Inc., permission to obtain a history of my prescribed drugs, during the course of my care.**

BY: ______________________ **(patient signature) MCHC Witness** ______________________ **Date:** __________________

Dental Insurance Information: Do you have dental insurance? ☐ Yes ☐ No

Name of Insurance:________________ Policy Number:_____________________ Group Number:__________________

Name on Insurance Card: _________________________ Insurance Is Provided to Patient By: ☐ Self ☐ Spouse ☐ Parent ☐ Other (specify)_________________

Secondary Insurance Coverage Information: Name of Insurance:_______________ Policy Number:_________________

Group Number:__________ Name on Insurance Card: _________________________

Insurance Is Provided to Patient By: ☐ Spouse ☐ Parent ☐ Self ☐ Other _________________(specify)

We are required to collect the following information because we receive federal funding. 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 ☐ Non-Hispanic or 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 currently live in your household (Including yourself): _______

Yearly Household Income (please check one): ☐ Less than $22,340. ☐ $22,341 to $30,260. ☐ $30,261. to $38180.

☐ $38,181. to $46,100. ☐ $46,101. to $54,020. ☐ $54,021. to 61,941. or more **If decline to answer, initial here:**_______

_____________________________ Signature of Patient/Legal Representative

_____________________________ Printed Name of Patient/Representative

_______________ Date

MASCOMA COMMUNITY HEALTHCARE, INC.
PO BOX 550 ~ 18 ROBERTS ROAD
CANAAN, NH 03781 ~ 603-523-4343

Dental History Form

Patient Name:___________________________ Date of Birth:________ Today's Date:________
Occupation _____________________________ Phone number: ___________________________

When was your last dental visit? _______________ Reason? _____________________
Name of your last dentist? _________________ When were your last X-Rays taken? ________
Have you had any periodontal (gum) treatment? [ ] yes [ ] no
Do you wear any removable dental appliances (complete denture, partial denture)? [ ] yes [ ] no
How often do you brush your teeth? __________________ Floss?___________________

Do you or have you ever had the following

[ ] Bleeding or sore gums
[ ] Unpleasant taste or bad breath
[ ] Burning of tongue or lips
[ ] Frequent blisters on lips or in mouth
[ ] Swelling or lumps in mouth
[ ] Clicking or popping of jaw
[ ] Clenching or grinding
[ ] Sensitivity to hot
[ ] Sensitivity to cold
[ ] Sensitivity to sweet
[ ] Sensitivity to biting
[ ] History of locked jaw
[ ] Shifting of teeth
[ ] Change in bite
[ ] Dry mouth
[ ] Headaches
[ ] Loose teeth
[ ] Food impaction

Do you like your teeth or smile [ ] yes [ ] no
Are you currently experiencing a dental problem [ ] yes [ ] no

____

Goals for dental treatment

____

____

Have you had a serious/difficult problem associated with any previous dental treatment?

____

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 neck radiation or chemotherapy? [ ] yes [ ] no
Are you currently taking any blood thinners? [ ] yes [ ] no
Are you currently taking any corticosteroid medications? [ ] yes [ ] no

Current or former tobacco use [ ] yes (list frequency/# years) ___________________ [ ] no
Current or former marijuana use [ ] yes (list frequency/# years) ___________________ [ ] no
Current or former drug abuse [ ] yes (list frequency/# years) ___________________ [ ] no
Drinks of alcohol per week [ ] yes (list frequency/# years) ___________________ [ ] no

MASCOMA COMMUNITY HEALTHCARE, INC.
PO BOX 550 ~ 18 ROBERTS ROAD
CANAAN, NH 03781 ~ 603-523-4343

Past Medical History: (Please check all that apply) or check none below apply [ ]

[ ] High blood pressure	[ ] Asthma	[ ] Colitis	[ ] HIV
[ ] High cholesterol	[ ] Emphysema	[ ] Hepatitis	[ ] Herpes
[ ] Pacemaker	[ ] Tuberculosis	[ ] Blood clots	[ ] Depression
[ ] Congestive heart failure	[ ] Diabetes	[ ] Anemia	[ ] Anxiety
[ ] Heart attack	[ ] Arthritis	[ ] Blood transfusion	[ ] Cancer
[ ] Coronary artery disease	[ ] Thyroid disorder	[ ] Bleeding disorders	[ ] Glaucoma
[ ] Stroke	[ ] Seizure disorder	[ ] Kidney disorder	[ ] Mental disability
[ ] Dementia/Alzheimers	[ ] Joint replacement	[ ] Radiation therapy	[ ] Physical disability
[ ] Acid reflux	[ ] Osteoporosis	[ ] Chemotherapy	[ ] Eating disorder

Past surgical history: (Please listy type of surgery and approximate date of surgery)

____

____

____

Other personal medical problems or hospitalizations

____

____

____

Medications: (List all prescribed medications, over the counter medications, vitamins, supplements, and herbs)

Medication name	Strength	Frequency

Allergies: [ ] yes (please list below) [ ] No known allergies

Allergy	Type of reaction

Patient Signature: ________________________ Date: __________

'MASCOMA COMMUNITY HEALTH CENTER

RELEASE OF INFORMATION FORM

AUTHORIZATION FOR RELEASE OF INFORMATION 2018

HIPAA COMPLIANT RELEASE

Patient's Name:______________________________________DOB: _______________________________

Release of Information ***FROM:*** ____

TO: ***Mascoma Community Health Center***
PO Box 550
Canaan, NH 03741
ATTN: MEDICAL RECORDS DEPT.
Phone: 603.523.4343 Fax: 866.277.5893

Dental Records can be emailed to dentalrecords@mascomahealth.org

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**

☐ 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
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 I have a 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)	(Printed Name)	(Relationship to Patient if Representative)	(Date)
____________________	________________	____________	
(Witness Signature)	(Printed Name)	(Date)	

MASCOMA COMMUNITY HEALTH CENTER

RELEASE OF INFORMATION FORM

Release (Disclosure) of Your Protected Health Information To Persons of Your Choice

Mascoma Community Health Center (MCHC) will release your protected health information to a person or persons whom you choose. However, you must give us the name(s) and phone numbers of the person(s), tell us what information we are allowed to disclose, and authorize us to do this by signing your name on this form. **If you do not want your protected health information released to anyone, disregard this form.**

Contact #1: Release information to the following person and for the purpose(s) as 'checked' below:

Name:___________________ Relationship:______________ Phone:___________ Other Phone:___________

I give permission for MCHC to give the above-named person information about the following: (check all that apply):
___ Appointment information (date, time, with whom, for what)
___ Information and results from any tests or diagnostics such as labs, X-rays,
and other clinical information such as medications, diagnoses, prognoses, etc.
___ Emergency contact, only

Contact # 2: Release information to the following person and for the purpose(s) as 'checked' below:

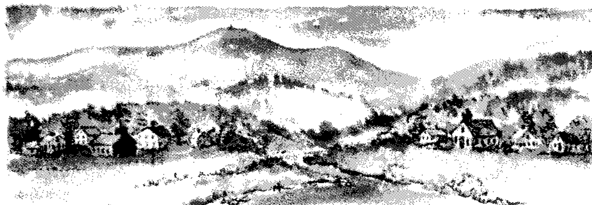
Name:___________________ Relationship:______________ Phone:___________ Other Phone:___________

I give permission for MCHC to give the above-named person information about the following: (check all that apply):
___ Appointment information (date, time, with whom, for what)
___ Information and results from any tests or diagnostics such as labs, X-rays,
and other clinical information such as medications, diagnoses, prognoses, etc.
___ Emergency contact, only

Signed:_______________________ Date:___________

MASCOMA COMMUNITY HEALTH CENTER

Consent to Treat, Payment, Certification



Treatment Consent & Certification and Payment Policy Acknowledgement

Consent & Certification

I give my consent for Mascoma Community Health Center (MCHC) to conduct treatment and to receive payment for health care services. I have received a copy of Mascoma Community Health Center's Notice of Privacy Practices, and understand MCHC may disclose my health information for the purpose of providing and coordinating treatment, conducting health care operations, providing health information, and obtaining payment. This consent gives permission to obtain medical records for continuity of care and to obtain a history of prescribed drugs during the course of your medical care. I certify that the information I have given is complete and accurate to the best of my knowledge. I understand that failure to provide accurate information may result in termination of services at Mascoma Community Health Center, and report of the failure to my insurance company, and/or the federal government.

This consent remains in effect until I notify MCHC and I understand that I have the right to withdraw this consent at any time. Doing so will not affect any actions which were taken by MCHC before I withdrew this consent.

Patient Name: ______________________________ DOB: ________________

______________________________ Date: ________________

Signature of: Patient / Parent / Guardian (Please CIRCLE One)

** Please note that if you are signing the consent as a patient's guardian, we will need to be provided with a copy of the current guardianship decree. **

Payment Acknowledgement

I have received a copy of Mascoma Community Health Center's Payment Policy and understand that **I am responsible** for any deductibles, co-payments, or non-covered services. I understand that my failing to do so may result in my being submitted to collections, reported to credit bureaus, and/or terminated from receiving services at Mascoma Community Health Center.

Patient Name: ______________________________ DOB: ________________

______________________________ Date: ________________

Signature of: Patient / Parent / Guardian (Please CIRCLE One)

MASCOMA COMMUNITY HEALTH CENTER

NEW PATIENT INFORMATION

HELP US TAKE CARE OF YOU

At Mascoma Community Health Center (MCHC), we take pride in providing our patients with the very best health care, at an affordable price. **Please help us by following these simple rules:**

Co-Pays are due at the time of service

If you have insurance, please bring your insurance card with you. If you have a co-pay, please know how much your co-pay is and be ready to pay it when you come for your visit. Insurance companies require us to collect the co-pay at the time of service. If you do not pay your co-pay, we cannot continue to make appointments for you.

24-hour notice is needed to cancel or reschedule your appointment

Our schedules are getting full, and we often have a waiting list for patients to get an appointment. By providing 24-hours' notice, it allows us time to schedule a patient that may be waiting for care.

Missed (No-Show) Appointments

If you do not provide us 24-hour notice to cancel or reschedule your appointment, and you do not show up at the appointed time, you will be considered a "No Show". If you no-show two consecutive appointments or three total appointments you may be discharged from the practice.

48-hour notice is needed for prescription refill requests

Please keep track of ALL of your prescriptions. When you need a refill, call us, or your pharmacy, AT LEAST 48 hours before you run out of your medication, so that we can process the prescription. We DO NOT refill prescriptions after normal business hours, or on weekends. Please also understand that some medications can't be refilled without an office visit, blood and/or urine testing, or other lab tests.

If you don't have insurance, we offer a Sliding Fee Scale

If you don't have insurance, please ask us about eligibility requirements for our sliding fee scale program. If you need to sign up for NH Medicaid, Medicare, or need assistance with other programs, please ask us for assistance. We have care coordination services to help you access the resources you may need.

Keep your Health Care "Up-To-Date"

It is important for people of all ages to have regular "wellness visits" with your health care provider. Although you may not require frequent visits to your provider, health care standards and regulations require us to keep accurate records of our patients. If you have not seen your provider in over three years, you will receive a notice from MCHC, asking if you wish to remain a patient here, and to schedule a wellness visit. If you wish to transfer, or stop your care here at MCHC, please let us know.

Contact our office with billing questions

If you get a bill, you can help us by paying it upon receipt. If you believe there is a mistake with the bill, or you need help understanding it, please contact our billing department at 603-523-4343.

THANK YOU FOR GIVING US THE OPPORTUNITY TO SERVE YOU AND FOR WORKING WITH US TO MAKE OUR HEALTH CENTER A CARING, HELPFUL, AND SUCCESSFUL PART OF THE COMMUNITY!

MASCOMA COMMUNITY HEALTH CENTER

NEW PATIENT INFORMATION

Mascoma Community Health Center Payment Policy

Thank you for choosing Mascoma Community Health Center (MCHC). Prompt payment for the services that you receive ensures that we can continue to provide you and our community with affordable, quality medical care. The following explains the guidelines and rules of our Payment Policy. **Please read it, and feel free to ask us questions.**

RESPONSIBILITY

As a patient of MCHC you are responsible for payment of services.

ABOUT INSURANCE

MCHC participates in most insurance plans, including Medicare and Medicaid. **Your insurance benefit is a contract between you and your insurance company; knowing your insurance benefits and co-pay amount is your responsibility.** You must contact your insurance company with any questions you may have about your coverage. Please be aware that you might be responsible for the entire amount of the bill, if your insurance company does not have a contract with MCHC.

Please note the following:

1. **Co-payments MUST** be paid at the time of service. This arrangement is part of your contract with your insurance company. **Failure of MCHC to collect co-payments from patients can be considered fraud**. Please help us in upholding the law, by paying your co-payment at each visit.
2. **If you have an active insurance card**, we will bill your insurance company. If any balance remains, you are responsible for its payment.
3. **If you do NOT have an active insurance card, you will be responsible for payment of the service at the time the service is provided.**
4. MCHC accepts personal checks, credit cards, and cash. **If you need financial help to pay your bill**, ask to speak with our billing office, to set up payment options. MCHC offers a **Sliding Fee Scale,** available to income eligible patients. A payment plan can be arranged before you make your appointment.

OTHER THINGS TO KNOW:

- **IF YOUR INSURANCE CHANGES**, call us before your next visit. MCHC will make the necessary changes to help you receive your maximum benefits. **If your insurance company has not paid your claim within 45 days, you will be responsible for outstanding balances before additional services are provided.**

- **PROOF of insurance** – **MCHC must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide the correct insurance information in a timely manner, you will be responsible for the balance of a claim at time of service.

- **NON-COVERED services** - Please make sure that you know which services are covered by your health insurance. If you receive services at MCHC that are not covered by your insurance plan, you will be responsible for paying for these services.

- **CLAIMS submission** - MCHC submits your claims, and assists you in any way we can, to help get your claims paid. You may be asked by your insurance company to supply certain information directly to them, such as more information about when or where an injury happened, if it was work-related, etc. It is your responsibility to supply your insurance company with information that they request from you. If your claim is not paid because you have not supplied requested information, you will be responsible for paying the claim..

NONPAYMENT –If your account is over 60 days past due, you will receive a letter giving you 10 days to either pay the balance in full, or make a partial payment and set up a payment plan with our billing office. **If you do not respond to the letter, you will be given an additional 30 days of urgent care only from the initial date of notice. You will need to pay for urgent care services provided at the time of service. At the end of the 30 days, you could be discharged from MCHC due to non- payment.** In order to be reinstated as a patient at MCHC, you will need to pay all past due balances in full and establish a payment plan for future services.