Community Dental Care of Claremont: Patient Registration

Patient's Full Name _____Date of Birth _____/_____/_____

Preferred Name/Nick name:_____ Current Gender (circle one): M F O (Other) Sex assigned at birth: M F

Mailing Address _____

Physical Address (if different from mailing)_____

Home phone _____Work phone_____ Cell phone_____

Social Security # _____Email Address _____

If patient is a minor are you the parent or legal guardian? YES NO

Primary Care Physician name and Phone Number_____

Emergency contact _____ Phone _____

Artificial Joints or Valves (please indicate)	Yes No	HIV/AIDS	Yes No
Anemia	Yes No	Heart Murmur	Yes No
Arthritis	Yes No	Jaundice	Yes No
Asthma	Yes No	Latex Allergy	Yes No
Bisphosphonates	Yes No	Kidney Disease	Yes No
Blood Disease	Yes No	Liver Disease	Yes No
Cancer	Yes No	Mental Disorders	Yes No
Chemotherapy	Yes No	Nervous Disorders	Yes No
Diabetes	Yes No	Pacemaker	Yes No
Dizziness	Yes No	Radiation Treatment	Yes No
Epilepsy	Yes No	Respiratory Problems	Yes No
Excessive Bleeding	Yes No	Rheumatic Fever/Scarlet Fever	Yes No
Fainting	Yes No	Sinus Problems	Yes No
Frequent Headaches	Yes No	Steroid use in the last year	Yes No
Glaucoma	Yes No	Stomach Problems	Yes No
Head Injuries	Yes No	Stroke	Yes No
Heart condition of any kind	Yes No	Swollen Glands	Yes No
Tumors	Yes No	Thyroid	Yes No
Ulcers	Yes No	Tuberculosis	Yes No
Hepatitis	Yes No	Tobacco Use	Yes No
High Blood Pressure	Yes No	Venereal Disease/ STD	Yes No
ADHD	Yes No		

Please explain any Yes answers:

_____

Please list any other medical conditions: _____

Have you ever taken medication for Osteoporosis, Paget's or Bone Disease? YES NO

Allergies to medications or other allergies: _____

Please list all over-the-counter or prescription medications, herbal supplements, vitamins, etc.

_____

_____

Recreational Drug Use*:* YES NO If yes, please describe_____

Do you smoke or use smokeless tobacco or products? YES NO

If yes, how much do you smoke/chew per day? _____

For Women Only:

Are you currently taking birth control pills?	YES NO	Are you pregnant?	YES NO
If yes, what month?		Are you nursing?	YES NO

DENTAL HISTORY

What brings you to our office today? _____

How did you hear about our practice? _____ When were you last seen by a dentist?_____

Previous dentist: _____ Reason for last dental visit_____

Have you had dental x-rays taken in the last year? YES NO Date of last cleaning_____

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

If the patient is a child, are they currently taking a fluoride supplement? YES NO

Have you ever been required to take antibiotics before dental treatment? YES NO If yes, why? _____

Please circle the most appropriate answer(s)

Are your teeth sensitive to:	Hot Cold Sweet	Do you clench or grind your teeth?	Yes No
Do your gums bleed when you brush or floss?	Yes No	Have you ever had any head, neck, or jaw injuries?	Yes No
Do you feel pain in any of your teeth?	Yes No	Does food tend to get caught between your teeth?	Yes No
Do you have any lumps or sores in your mouth?	Yes No	Have you noticed any loosening of your teeth?	Yes No
Have you ever had prolonged bleeding after an extraction?	Yes No	Do you wear dentures or partials?	Yes No

Have you ever had a negative dental experience? YES NO
If yes, please briefly describe: _____

PRIMARY DENTAL INSURANCE

Policy Holder: _____Date of Birth_____

ID#_____Group#_____

Policy Holders Employer Name_____

Patient's relationship to insured (circle one): SELF SPOUSE CHILD OTHER

Insurance Plan Name_____

SECONDARY DENTAL INSURANCE

Policy Holder: _____Date of Birth_____

ID#_____Group#_____

Policy Holder Address_____

Policy Holder Employer Name_____

Patient's relationship to insured (circle one): SELF SPOUSE CHILD OTHER

Insurance Plan Name_____

AUTHORIZATION AND CONSENT FOR TREATMENT: Please Read Carefully!

- I authorize Community Dental Care of Claremont's dental providers to provide routine diagnostic, preventive and restorative dental services for me or my dependent named above. I understand that I will be given the opportunity to ask any questions I may have regarding this treatment. I understand that a perfect result cannot be guaranteed. I acknowledge that during treatment it may be necessary to change or add procedures because of conditions found while working on the tooth/teeth that were not detected during examination and that I will be informed of these changes, whenever feasible.
- ***For parents/legal guardians:*** I authorize routine dental treatment and services for my child without a parent/legal guardian present (unaccompanied) or accompanied by an adult other than myself. Routine dental care may include, but is not limited to: dental evaluation, exam, dental x-rays, cleaning of teeth, fluoride treatment, placement of sealants and placement of fillings as deemed necessary by the providers of CDCC. **Extractions or root canal therapies will NOT be performed unless I am present to give consent.**
- I authorize CDCC to take videos and/or photographs of me and/or my child/dependent during my visit, without further notice or compensation, to be used for education or marketing purposes including, but not limited to, professional conferences, workshops and on our website.
- I certify that the above information is accurate. I understand that providing false information can be dangerous to my health.
- I authorize Community Dental Care of Claremont to release information including diagnosis and treatment for me or my dependent to third party payors. I authorize and request my dental insurance company to pay all insurance benefits otherwise payable to me directly to Community Dental Care of Claremont.
- I understand that income and demographic information may be shared with State, Federal and private grants. I have been provided a copy of Notice of Privacy Practices. I acknowledge receipt and understanding of these documents.
- I agree to be responsible for payment of all services rendered to me or my dependent. I understand that there may be fees associated with my dental care that are my responsibility and due at the time services are rendered.

By signing, I am agreeing to all of the authorization and consent listed above.

_____ Date: _____

Patient/Parent/Legal Guardian

Confirmation Policy

Effective immediately: In order to guarantee your reservation with our office you MUST confirm with us no later than 7:00 am on the day before your appointment. If you fail to contact our office to make the necessary confirmation we will not be able to guarantee your reservation and your time may be used for the treatment of other patients.

Your appointment time is your responsibility to remember. As a courtesy, we will attempt to contact you (2) business days prior to your appointment to confirm. If we are unable to reach you we will leave a message reminding you to call us to confirm.

We pay the entire staff to be here for your reserved appointment time. If you do not confirm your reservation we will have no other choice but to offer it to another patient in order to cover our expenses.

We still require two (2) business days' notice to cancel or change your appointment time. Failure to provide sufficient notice may result in not accepting advance reservations for your family and you will be placed on a same day only basis.

I have read and understand the cancellation policy.

_____ _____

Signature of Patient, Parent or Guardian Date

Community Dental Care of Claremont
Policy Agreement

Dental Services Available –

- Community Dental Care of Claremont provides basic preventive, restorative, surgical, prosthetic and educational dental services for children and adults of Sullivan County

Appointments –

In order to give every dental patient the attention they need we ask that you:

- Be on time for your appointment
- If you can not keep your appointment be sure to give us 2 business days notice – 603-287-1300

Community Dental Care of Claremont will not be able to continue to schedule appointment for patients who repeatedly break their appointments. An appointment is considered to have been broken if any of the following occur:

1. The patient fails to show up for an appointment
2. The patient arrives more than 10 minutes late for a scheduled appointment
3. The patient calls to cancel an appointment with less than 2 business days notice

When a patient has repeated broken appointments, the patient will not be allowed to schedule any further routine appointments. The patient may call daily for a possible same day appointment as the schedule allows or emergency services only. Additional broken appointments could lead to permanent dismissal from the dental practice.

Payment – Community Dental Care of Claremont offers payment options to help make dental care affordable to our patients. We will work with each patient to determine their financial responsibility and provide them with an estimate for dental services. ***Dental services must be paid for upon arrival on the day of treatment unless other financial arrangements have been made ahead of time.*** Please be sure to discuss any concerns you may have regarding your payment and payment options with the Dental Receptionist ***before*** the day of treatment.

Address and Telephone Number Changes – It is your responsibility to notify Community Dental Care of Claremont with any address and/or telephone number changes. If we are unable to contact you by mail or telephone to confirm your appointment, your appointment may be cancelled.

The staff of Community Dental Care of Claremont will make every effort to treat you with respect and courtesy and they expect that you will show them the same respect and courtesy in return.
Community Dental Care of Claremont reserves the right to terminate the patient relationship.

I have read, understand and agree to abide by these policies.

_____ _____

Patient or Legal Guardian if patient is under 18 years old Date

Community Dental Care of Claremont
One Tremont Street
Claremont, NH 03743

ACKNOWLEDGEMENT OF RECEIPT OF *NOTICE OF PRIVACY PRACTICES AND DENTAL RESTORATIVE MATERIALS*

You May Refuse to Sign This Acknowledgement

I, _____ (patient name) have reviewed a copy of this office's **Notice of Privacy Practices and Dental Restorative Materials.**

Patient Name (Please print)

Signature of Patient (or Parent/Legal Guardian if Patient is a Minor)

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices and Dental Restorative Materials, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

Community Dental Care of Claremont

Responsible Party Information

*If the patient is under the age of 18 or has a guardian, please fill out the following information regarding the **responsible party**:

Patient Name(s): _____

_____

Responsible Party:

Name: _____ _____ _____
(Last) (First) (MI)

Address: _____

_____

_____

Responsible Party:

Date of Birth _____ **Social Security #**_____

Relationship Status: Married, Single, Partnered, Divorced or Other _____

Phone: _____ _____ _____
(Home) (Work) (Mobile)

Relationship to patient: _____

Signature_____ **Date** _____