



## **Important Information For New Patients of Community Dental**

1. In order to best serve you as a patient of Community Dental please complete the attached paperwork and bring or mail it to the center where you are seeking services. You will then receive a call when an appointment is available.

**Community Dental Biddeford**, 57 Barra Rd., Suite 3, Biddeford, ME 04005 (207) 282-1305

**Community Dental Farmington**, 131 Franklin Commons, Ste I, Farmington, ME 04938 (207) 779-2659

**Community Dental Lewiston**, 177 Main St., Lewiston, ME 04240 (207) 777-7442

**Community Dental Portland**, 640 Brighton Ave, Portland, ME 04102 (207) 874-1028

**Community Dental Rumford**, 60 Lowell St, Rumford, ME 04276 (207) 369-3600

2. On the day of your appointment, please arrive **10 minutes before** your scheduled appointment. It is required that you bring your **insurance card** with you to each appointment.
3. A **parent or guardian** must accompany patients under 18 years of age and remain at the Center during the length of the appointment.
4. **Payment** for dental services is due at the same time you receive the dental care. There is a \$25 fee for any check payments returned for non-payment.
5. If you are requesting consideration for our income based **sliding fee** scale, you must complete the sliding fee application and include copies of all proof of household income with your completed paperwork. This may include...
  - **A copy of your most recently filed Tax Return or current household W-2s.**
  - **A copy of your paycheck stub from the last 2 months with Year-to-Date total**
  - **A copy of your TANF Check, SSI/SSDI Check, Retirement Check, VA Benefits or Bank statement of Direct Deposit for any of the above**
  - **Alimony, child support payment, City or General Assistance Voucher**Proof of income must be updated annually. Full fees will be applied if documentation is not received with application.

## **Broken Appointment Policy**

Community Dental may restrict patients from scheduling appointments if they have **two or more broken appointments**. An appointment is considered to have been broken if any of the following occur:

1. The patient fails to appear for the appointment, or
2. The patient arrives more than 15 minutes late for a scheduled appointment, or
3. The patient cancels an appointment with less than 24 hours notice

## COMMUNITY DENTAL PATIENT HEALTH HISTORY

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex: M  F   
 Mailing Address: \_\_\_\_\_ Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Social Security # \_\_\_\_\_ Marital Status: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_  
 Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_ Emergency # \_\_\_\_\_

Please circle the number (only one) of the racial category that pertains to you (optional):

1. American Indian or Alaskan Native	2. Asian	3. Black or African-American	4. African
5. Native Hawaiian or other Pacific Islander	6. White/Caucasian	7. Some other Race	8. Two or more Races

Are you Hispanic or Latino? Yes  No

**GENERAL HEALTH:** Excellent  Good  Fair  Poor

Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Have you ever been hospitalized for an illness or operation? \_\_\_\_\_ If Yes, please indicate date and reason \_\_\_\_\_

What medication are you taking now? \_\_\_\_\_  
 What medications are you allergic to? \_\_\_\_\_

Have you ever taken an antibiotic pre-medication before dental treatments? Yes  No

Are you taking Coumadin or any other blood thinner? Yes  No   
 Have you ever had cobalt or radiation treatments? Yes  No   
 Have you had any bleeding requiring special treatment? Yes  No   
 Do you have excessive urination and/or thirst? Yes  No   
 Have you been denied for giving blood for any reason? Yes  No

**WOMEN - ARE YOU PREGNANT?** Yes  No  Due Date: \_\_\_\_\_  
 Do you use tobacco? Yes  No  If yes, do you chew  smoke

- Please check if you have been treated or are under treatment for any of the following:
- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> AIDS/HIV                | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Alcohol/Drug Abuse      | <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> Jaundice                | <input type="checkbox"/> Sinus Problems    |
| <input type="checkbox"/> Allergies _____         | <input type="checkbox"/> Glaucoma           | <input type="checkbox"/> Kidney Disease          | <input type="checkbox"/> Stomach Problems  |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Growths/Tumors     | <input type="checkbox"/> Liver Disease           | <input type="checkbox"/> Stroke            |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Head Injuries      | <input type="checkbox"/> Lung Disease            | <input type="checkbox"/> Tuberculosis      |
| <input type="checkbox"/> Artificial Joints/Pins* | <input type="checkbox"/> Heart Disease*     | <input type="checkbox"/> Mental/Nervous Disorder | OTHER:                                     |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Heart Murmur*      | <input type="checkbox"/> Pacemaker               | <input type="checkbox"/> _____             |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Herpes             | <input type="checkbox"/> Respiratory Problems    | <input type="checkbox"/> _____             |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Rheumatic Fever*        | <input type="checkbox"/> _____             |

**DENTAL HEALTH:** When was your last dental visit? \_\_\_\_\_ Where? \_\_\_\_\_  
 Have you ever had any serious problems associated with previous dental treatment? Yes  No   
 If yes, please explain \_\_\_\_\_  
 How often do you brush? \_\_\_\_\_ per \_\_\_\_\_. Do your gums bleed? While Brushing  While Flossing   
 Please add anything you feel is important for us to know: \_\_\_\_\_

Please sign and date this form each time it is updated:

<input checked="" type="checkbox"/>			
	SIGNATURE	DATE	Provider Initials
<input checked="" type="checkbox"/>			
	SIGNATURE	DATE	Provider Initials
<input checked="" type="checkbox"/>			
	SIGNATURE	DATE	Provider Initials
<input checked="" type="checkbox"/>			
	SIGNATURE	DATE	Provider Initials
<input checked="" type="checkbox"/>			
	SIGNATURE	DATE	Provider Initials





Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Maine Care ID # \_\_\_\_\_ (If you have other insurance please continue.)

Employer Name \_\_\_\_\_

Insurance Co. Name \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber Name \_\_\_\_\_ DOB \_\_\_\_\_

Subscriber's SS# \_\_\_\_\_ Insurance ID# \_\_\_\_\_

I hereby authorize payment of dental benefits to Community Dental. I agree to be responsible for all charges and services and materials not paid by my dental plan and/or Maine Care. To the extent permitted under applicable law, I authorize release of any information relating to my dental claims.

Sign \_\_\_\_\_ Date \_\_\_\_\_  
SIGNATURE (PARENT/GUARDIAN IF PATIENT IS A MINOR)

**OFFICE USE ONLY**

Effective Date \_\_\_\_\_ Annual starting date \_\_\_\_\_

Annual Max \_\_\_\_\_ Deductible \_\_\_\_\_ Preventive Basic Major

Preventive % \_\_\_\_\_ Basic% \_\_\_\_\_ Major% \_\_\_\_\_

Endo: Basic or Major Prosthodontics: Basic or Major

Periodontics: Basic or Major Oral Surgery: Basic or Major

Frequency: Exam \_\_\_\_\_ Prophy \_\_\_\_\_ BWX \_\_\_\_\_ FMX \_\_\_\_\_

Fluoride \_\_\_\_\_ to age \_\_\_\_\_

Sealants: Bicuspids Molars to & including age \_\_\_\_\_ ONCE IN \_\_\_\_\_

Posterior Composite % \_\_\_\_\_ Reduced to Amalgam?: yes no

Prosthodontics: once in \_\_\_\_\_

Emergency Exam \_\_\_\_\_ Palliative Treatment % \_\_\_\_\_

Implants \_\_\_\_\_ Nitoguards % \_\_\_\_\_ Due to Bruxism?: yes / no

Missing Tooth Clause yes no

Waiting Periods: yes no Preventive \_\_\_\_\_ Basic \_\_\_\_\_ Major \_\_\_\_\_

Secondary insurance Clause \_\_\_\_\_

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**\*\*You May Refuse to Sign This Acknowledgement\*\***

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
{Please Print Your Name and the Name(s) of your dependants we treat at this facility}

\_\_\_\_\_  
{Signature}

\_\_\_\_\_  
{Date}

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### For Office Use Only

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, 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 Office where PHI is located: \_\_\_\_\_



## Broken Appointment Policy

Community Dental's mission is to provide affordable, accessible, quality oral health services for children and adults. When patients break appointments with too little or no prior notice it does not allow us to treat other patients in need of dental care.

After **two** broken appointments, a patient will no longer be granted the privilege of scheduling appointments in our centers. An appointment is considered to be broken if:

- The patient fails to keep the appointment
- The patient is more than 15 minutes late for a scheduled appointment
- The patient cancels the scheduled appointment with less than 24 hours notice

Community Dental is dedicated to achieving our mission. Our broken appointment policy was developed to enable us to provide dental services to as many patients as possible. Thank you for your understanding.

I have read and understand the Community Dental Broken Appointment policy.

Name: \_\_\_\_\_ Date: \_\_\_\_\_