Community Dental
1102 S Virginia Street, Suite B
Hopkinsville, KY 42240
For Appointments
Call: 270-632-3088
Fax: 270-632-8212

Patient Information

_____, _____, _____
Last Name *First Name* *Middle Name*

Preferred Name? _____
Address:_____ Zip Code: _____
Home Phone: (___)_____ Cellular: (___)_____Work: (____)_____
Email Address:_____ Preferred Communication:___Phone ___Text ___Email
Preferred Phone Contact: ___ Home___ Cell ___ Work
Circle Gender at Birth: M / F SSN: _____ - _____ -_____ Date of Birth: _____
Gender Identification (please choose one): ___ Male ___ Female ___ Transgender Other:_____
Sexual Orientation (please choose one): ___ Lesbian or Gay ___ Straight ___ Bisexual ___ Other
Marital Status: ___Married ___ Divorced ___Separated ___Single ___Widow / Widowed

Race: ___Native American/Alaskan Native ___Asian ___Black/African American ___Native Hawaiian ___White

Ethnicity: ___Hispanic / Latino ___Non-Hispanic / Non-Latino Other:_____
Preferred Language: ___English ___Spanish Other_____
Interpreter Needed? ___Yes ___No
Living Situation:___ Homeless ___ Not Homeless___ Transitional___ Doubling Up

Agricultural Worker: ___ Not a Migrant Agriculture Worker ___ Migrant Agriculture Worker

Are you a U.S. Veteran? ___Yes ___No
Who is / was your last Dental Care Provider? _____
Reason for Transfer of Care (if transferring):_____

How did you hear about us?_____

IN CASE OF EMERGENCY

Contact (name):_____Phone(s):_____
Address:_____Relation:_____
Preferred Pharmacy:_____Phone:_____

INSURANCE INFORMATION

Primary Insurance: _____ ID#_____ Group#_____
Subscriber's Name:_____ DOB:_____ Phone#_____
Secondary Insurance:_____ ID#_____ Group#_____
Subscriber's Name:_____ DOB:_____ Phone#_____
Subscriber Address (if different than the patient): _____

Required Information and Acknowledgements

Release of Medical Records

- In the event that my physician / provider recommends (and I agree to) referral to a specialist, an outside Health Care Center, or other outside medical provider, I hereby authorize Community Dental to release my medical records as required to the indicated specialty physician, provider and/or the referral health center for the purpose of continuity of care.
- I understand that this release of my medical information is required to facilitate a referral (which is made by my Community Dental provider and accepted by me stays in force unless I revoke it in writing to Community Dental.

CONSENT for TREATMENT

- In seeking medical care from Community Dental, I do hereby voluntarily consent to such examination and treatment as is deemed necessary by Community Dental. I understand the practice of medicine is not an exact science, and that diagnosis and treatment involve risks of injury or even death. I acknowledge that Community Dental providers have made no guarantees to me as a result of examination or treatment.

Patient Acknowledgement:

- **Cancellation of Appointments.** I agree to schedule appointments for my treatment. I agree that I will call and cancel my appointment at least 24 hours prior to the appointment time, if cancellation is necessary. I understand that if I have three missed or cancelled appointments, I may be discharged from the Health Center practice.
- **No Call / No Show.** I understand that missing 3 appointments within 12 months as a no call/no show **may** cause me to be discharged from the practice.
- **Notice of Privacy Practices.** I have received a copy of the Notice of Privacy Practices.
- **Responsibility for Payment.** For and in consideration of services rendered, or to be rendered, to the named patient, I or we, or either of us do hereby promise to pay Community Dental the full amount of all charges incurred. I/we understand that Community Dental will file commercial insurance as a courtesy. Community Dental will allow 30 days for the insurance to resolve the outstanding charges.

Patient / Representative Signature:_____ Date:_____

HOUSEHOLD INCOME INFORMATION

Note: ***As a Federally Qualified Health Center (FQHC), we provide Sliding Fee Scales which may help you with your health care expenses. To help us determine if you may qualify, please answer below.*** **This information is only used to obtain the grants we use to help those who do not have insurance and will not affect you in any adverse way.**

What is your annual household income?_____ How many people are in your household?_____

☐ No Income ☐ Less than 24,999 ☐ 25, 000 to 39,999 ☐ 40,000 to 59,999 ☐ 60,000 to 99,999

☐ 100,000 or more

HIPAA Authorization for use or disclosure of health information.

This form is for the use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPPA) Privacy Standards.

Print Name of Patient: _____

Date of Birth: _____ Social Security: _____

I. My Authorization

I authorize the following using or disclosing party: *Community Dental*

To use or disclose the following health information:

___All my health information

___My health information relating to the following treatment or condition: _____

_____

___My health information covering the period form _____(date) to _____(date)

___Other:_____

The above party may disclose this health information to the following receipient:

Name or Organization:_____

Address: _____

City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____ Email:_____

II. My Rights

I understand that I have the right to revoke this information, in writing, at any time, except where uses or disclosures have already been based upon my permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I may do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPPA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

Signature of Patient:_____ Date:_____

If the patient is a minor or unable to sign, please complete the following:

Patient is a minor: _____ years of age

Signature of Authorized Representative:_____

____Parent ____Legal Guardian ___Court Order ___Other:_____

Dental History:

1. What is your main dental concern at this time? _____
2. What is the name of your previous dentist? _____
   When did you last see your previous dentist? _____ Why? _____
   When were your last dental x-rays taken? _____
3. How often do you brush your teeth? _____ How often do you floss? _____
4. What other aids do you use to clean your teeth? _____
5. Check any of the following that you may have:

- o Pain in the face
- o Pain inside the mouth
- o Pain in your ears
- o Frequent headaches
- o Jaw joint sounds
- o Teeth sensitive to heat
- o Teeth sensitive to cold
- o Difficulty flossing between teeth
- o Difficulty brushing between teeth
- o Food wedging between teeth
- o Poorly functioning teeth
- o Poorly fitting complete denture
- o Jaw locking or catching
- o Jaw pain or aching
- o Clenching or grinding teeth
- o Problems chewing
- o Poorly fitting partial denture
- o Dry mouth
- o Sores or ulcers in mouth
- o Burning mouth or tongue
- o White, red, or brown mouth lesions
- o Bad breath
- o Discolored teeth
- o Soft teeth, susceptible to decay
- o Difficulty opening mouth
- o Difficulty closing mouth
- o Recent change in bite
- o Lump or swelling in mouth
- o Loose teeth
- o Missing Teeth
- o Crooked teeth
- o Sore gums
- o Facial swelling
- o Snoring
- o Stop breathing during sleep
- o Other: _____

6. Are you currently experiencing any dental pain or discomfort? Yes / No
7. Do you have any special concerns about your mouth or teeth? Yes / No
8. Are you nervous about dental treatment? Yes / No
9. Have you ever had an unpleasant experience in a dental office? Yes / No
10. Have you ever experienced complications with a dental treatment? Yes / No
11. Do your gums bleed when you brush or floss? Yes / No
12. Have you ever been given instructions on how to brush or floss? Yes / No
13. Have you ever been treated for gum disease? Yes / No
14. Have you ever had an injury to your face, head, or neck? Yes / No
15. Do you use tobacco products in any form (smoking, chewing, snuff)? Yes / No
16. Do you have any oral habits that might affect your dental health? Yes / No
17. Do you like the way your teeth look? Yes / No
18. Have you ever worn braces or received orthodontic treatment? Yes / No
19. Do you receive fluoride treatment for your teeth? Yes / No
20. Do you have any other concerns not listed above? Yes / No
    If yes, please explain: _____

For Pediatric Patients:

21. Has your child ever been treated in an emergency room? Yes / No
22. Does your child have an emotional, mental or nervous disorder? Yes / No
23. Do you think your child will be an uncooperative patient? Yes / No
24. Has your child ever sucked a thumb or finger? Yes / No
25. Has your child inherited any family dental characteristics? Yes / No
26. Does your child receive any form of fluoride? Yes / No

The Preceding answers are true and correct to the best of my knowledge. If there are changes, I will inform the doctor at my next appointment.

_____ _____

Patient Signature Date Patient Name (Please Print)

Cardiovascular	○ Congestive Heart Failure ○ Heart Attack ○ Angina Pectoris or Chest Pain ○ High Blood Pressure ○ Heart Murmur ○ Mitral Valve Prolapse ○ Rheumatic Fever ○ Congenital Heart Defect ○ Artificial Heart Valve ○ Arrhythmia ○ Pacemaker/Defibrillator ○ Heart Transplant ○ Aneurysm ○ Other Heart Problem
Hematologic	○ Blood Transfusion ○ Anemia ○ Hemophilia ○ Leukemia ○ Sickle Cell Anemia ○ Tendency to bleed longer than normal
Neurologic	○ Vision Problems ○ Glaucoma ○ Earaches, ringing in ears ○ Hearing Loss ○ Severe Headaches ○ Fainting or Dizzy spells ○ Stroke ○ Epilepsy, Seizures, or Convulsions ○ Psychiatric treatment ○ Panic Attacks ○ Phobias
Gastrointestinal	○ Stomach/ Intestinal Ulcers ○ Colitis ○ Persistent Diarrhea ○ Hepatitis ○ Liver Disease ○ Yellow Jaundice ○ Cirrhosis ○ Eating Disorder
Pulmonary	○ Hay Fever ○ Sinus Problems ○ Allergies or hives ○ Asthma ○ Chronic Cough ○ Emphysema ○ Chronic Bronchitis ○ Tuberculosis (TB) ○ Breathing Difficulties
Derma/Muscular	○ Allergy to Latex ○ Skin Rash ○ Dark Moles/ Changes in skin ○ Night Sweats ○ Osteoarthritis ○ Rheumatoid Arthritis ○ Systemic Lupus ○ Artificial Joint
Endocrine	○ Diabetes ○ Thyroid Disease ○ Taking Cortisone or other steroid
Genitourinary	○ Urinate Frequently ○ Kidney/bladder problems ○ Dialysis ○ Kidney Transplant ○ Sexually Transmitted Diseases ○ HIV Positive ○ Multiple Sexual Partners
Other	○ Frequent Sore Throats ○ Enlarged Lymph Nodes ○ Use Alcohol ○ Use injectable Drugs ○ Drug or Alcohol Addition (current or recovering) ○ Tumor or Cancer ○ Radiation Therapy ○ Chemotherapy ○ Drug reactions If yes, Please List: _____ _____ _____ Disease, Problem or Conditions not listed: _____ _____

27. Are you currently taking bisphosphanatas? Yes / No
(ie. Fosomax, Reciast, Boniva, Actonel, Zometa)

28. Has a previous dentist or physician required you to take an antibiotic before receiving dental treatment? (Usually because of heart defect or artificial joints) Yes / No

29. Have you ever had a reaction to an anesthetic? Yes / No

30. When you walk up stairs, do you stop due to pain in the chest or fatigue? Yes / No

31. Do your ankles swell during the day? Yes / No

32. Have you gained or lost more than 10 lbs in the past year unintentionally? Yes / No

33. Are you on a special diet? Yes / No

Women: Are you pregnant or possibly pregnant? Yes / No

List any medications you are currently taking or supposed to be taking: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____