COMMUNITY DENTAL

NEW PATIENT PACKET

Pennyroyal Healthcare Services, Inc DBA Community Dental
1102 S Virginia Street Suite B - Hopkinsville, KY 42240 - 270-632-3088 - 270-632-6742 (Fax)

In order to help the check in process, please fill in ALL information.

PART A

Patient Information

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

What name would you like to go by? _____

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- male-to-female
☐ Transgender-female-to-male ☐ Non-Binary
Sexual Orientation (please choose one): ☐ Lesbian or Gay ☐ Straight or Heterosexual ☐ Bisexual
☐ Something Else ☐ Don't Know ☐ Choose Not To Disclose

Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widow / Widowed ☐ Unknown

Education: (choose the highest education level completed)
☐ None ☐ 1-6 grade ☐ 7-8 grades ☐ some high school ☐ GED ☐ High school diploma ☐ Associates Degree
☐ Bachelors' degree ☐ Masters' degree or higher ☐ Some College

Race: ☐ Native American/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ White
☐ Middle Eastern/North African ☐ Other

Ethnicity: ☐ Hispanic / Latino ☐ Non-Hispanic / Non-Latino
Other:_____

Preferred Language: ☐ English ☐ Spanish ☐ Other_____
☐ Interpreter Needed?

We offer interpreter services through AMN Healthcare language services

Living Situation: ☐ Homeless ☐ Not Homeless ☐ Transitional ☐ Doubling Up ☐ Street ☐ Other ☐ Unknown

Agricultural Worker: ☐ Migrant ☐ Seasonal ☐ Not an Agricultural Worker

Are you a U.S. Veteran? ☐ Yes ☐ No

IN CASE OF EMERGENCY

Please contact (name): _____Phone(s):_____

Address:_____ Relation:_____

Preferred Pharmacy:_____Phone:_____

INSURANCE INFORMATION (Complete this section only if your insurance card is not present)

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): _____

_____

RESPONSIBLE PARTY INFORMATION

Employment: ☐ Full Time Part Time ☐ Unemployed ☐ Full-Time Student ☐ Retired ☐ Active Military ☐ Unknown

Responsible Party Name: _____Employer Name:_____

Employer Address: _____Employer Phone:_____

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.
- **15 Minute Grace Period.** I understand the 15-minute grace period policy. If I arrive more than 15 minutes late, Community Dental reserves the right to reschedule your appointment. However, Community Dental may use discretion in allowing the appointment beyond the grace period
- **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.
- **Update Patient Information.** I am required to update paperwork annually. If my paperwork is outdated, I will arrive at least 30 minutes before my scheduled appointment. This allows ample time to complete the necessary forms, update medication list, and ensures the reception team can update electronic records and verify any new or changed insurance before the appointment.

Patient / Representative Signature:_____ **Date:**_____

V. 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

If you are interested to know more about our Sliding Fee Scale Program, please fill out the enclosed Sliding Fee Scale discount program section below.

A sliding scale **discount program is available for our uninsured and under-insured patients who may have difficulty paying.**

Pennyroyal Healthcare Services, Inc.

2025 Dental Sliding Fee Schedule
(Based on 2025 DHHS Federal Poverty Guidelines)
Effective February 2025

Poverty Level	Class A 100% or below	Class B 101%-125%	Class C 126%-150%	Class D 151%-200%	Class E > 200%
Family Size	$100	Pay 70%	Pay 80%	Pay 90%	Full Fee
1	$15,650	$19,563	$23,475	$31,300	$ 30,121
2	$21,150	$26,438	$31,725	$42,300	$ 40,881
3	$26,650	$33,313	$39,975	$53,300	$ 51,641
4	$32,150	$40,188	$48,225	$64,300	$ 62,401
5	$37,650	$47,063	$56,475	$75,300	$ 73,161
6	$43,150	$53,938	$64,725	$86,300	$ 83,921
7	$48,650	$60,813	$72,975	$97,300	$ 94,681
8	$54,150	$67,688	$81,225	$108,300	$ 105,441
For each additional person, add	$6,330				

**Patients are required to pay the full cost of labs and appliances (supplies) for dentures, crowns, bridges, extractions, root canals, etc

** Covered services include Preventative Dental Serivces (dentral screenings, oral hygiene instructions, oral prophulaxis, topical application of fluoride, x-rays and imaging, and fillings.

□ Yes, I am interested in information regarding the sliding scale program.

□ No, I am not interested at this time in the sliding scale program and I do not wish to disclose my income.

Signature: _____

Date: _____

Once the paper is signed, please return it to the receptionist.

HIPAA Authorization for Use or Disclosure of Health Information

This form is used when authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____

Date of Birth: _____ Social Security: _____

I. Authorization

I authorize the following party to use or disclose my health information:
Disclosing Party: Community Dental

I authorize the disclosure of the following health information (check all that apply):

☐ All of my health information

☐ My health information relating to the following treatment or condition: _____

☐ My health information covering the period from _____(date) to _____(date)

☐ Other: _____

This information may be disclosed to the following recipient:

Name/Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

II. Patient Rights

I understand that I may revoke this authorization in writing at any time, except to the extent that actions have already been taken based on this authorization.

I understand that I may not be able to revoke this authorization if its purpose was to obtain insurance.

I understand that information disclosed may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.

I understand that my treatment cannot be conditioned on signing this authorization, unless the purpose is to create health information for a third party or for research participation.

Signature of Patient: _____ Date: _____

If the patient is a minor or unable to sign:

Patient is a minor: _____ years of age

Signature of Authorized Representative: _____

Relationship: ☐ 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:

- ○ Pain in the face
- ○ Pain inside the mouth
- ○ Pain in your ears
- ○ Frequent headaches
- ○ Jaw joint sounds
- ○ Teeth sensitive to heat
- ○ Teeth sensitive to cold
- ○ Difficulty flossing between teeth
- ○ Difficulty brushing between teeth
- ○ Food wedging between teeth
- ○ Poorly functioning teeth
- ○ Poorly fitting complete denture
- ○ Jaw locking or catching
- ○ Jaw pain or aching
- ○ Clenching or grinding teeth
- ○ Problems chewing
- ○ Poorly fitting partial denture
- ○ Dry mouth
- ○ Sores or ulcers in mouth
- ○ Burning mouth or tongue
- ○ White, red, or brown mouth lesions
- ○ Bad breath
- ○ Discolored teeth
- ○ Soft teeth, susceptible to decay
- ○ Difficulty opening mouth
- ○ Difficulty closing mouth
- ○ Recent change in bite
- ○ Lump or swelling in mouth
- ○ Loose teeth
- ○ Missing Teeth
- ○ Crooked teeth
- ○ Sore gums
- ○ Facial swelling
- ○ Snoring
- ○ Stop breathing during sleep
- ○ 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	**Gastrointestinal**	○ Stomach/ Intestinal Ulcers ○ Colitis ○ Persistent Diarrhea ○ Hepatitis ○ Liver Disease ○ Yellow Jaundice ○ Cirrhosis ○ Eating Disorder	**Genitourinary**	○ Urinate Frequently ○ Kidney/bladder problems ○ Dialysis ○ Kidney Transplant ○ Sexually Transmitted Diseases ○ HIV Positive ○ Multiple Sexual Partners
Hematologic	○ Blood Transfusion ○ Anemia ○ Hemophilia ○ Leukemia ○ Sickle Cell Anemia ○ Tendency to bleed longer than normal	**Pulmonary**	○ Hay Fever ○ Sinus Problems ○ Allergies or hives ○ Asthma ○ Chronic Cough ○ Emphysema ○ Chronic Bronchitis ○ Tuberculosis (TB) ○ Breathing Difficulties	**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: _____ _____
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	**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		

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: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____