Community Health Connections

We take great care of you!

NEW PATIENT - DENTAL REGISTRATION FORM

Today's Date: _____

CHC Site Preference: □ Fitchburg □ Leominster □ Gardner □ MWCC Dental Hygiene School

Student Preference: _____

PATIENT INFORMATION:

Patient Name: _____ Date of Birth: ____/____/____

Street Address: _____

City, State, Zip: _____

Social Security Number: _____

Home Telephone Number: (____)-____-____

Cell Telephone Number: (____)-____-____

Work Telephone Number: (____)-____-____

E-Mail Address: _____@_____

EMPLOYMENT INFORMATION (PARENT/GUARDIAN IF MINOR):

Are you employed? □ Yes □ No

Occupation: _____

Company Name: _____

Company Address: _____

City, State, Zip: _____

Telephone: _____

INSURANCE INFORMATION:

Dental Insurance Company Name (ie: Masshealth, BC/BS, Delta, etc): _____

Member ID #: _____ Subscriber ID #: _____

Subscriber Name: _____ Subscriber DOB: _____

Medical Insurance Company Name (ie: Masshealth, BC/BS, Harvard Pilgrim etc): _____

Member ID #: _____ Subscriber ID #: _____

Subscriber Name: _____ Subscriber DOB: _____

EMERGENCY CONTACT INFORMATION:

Emergency Contact Name: _____

Relationship to Patient: _____

Home Telephone: _____

Cell Telephone: _____

X I have completed this form and certify that I am the patient or the duly authorized agent of the patient. I understand that my dental insurance carrier may pay less than the actual bill for services and I agree to be responsible for payment of all services.

Signature: _____ **Date:** _____

Print Name: _____

Fitchburg Community Health Center
326 Nichols Rd., Fitchburg, MA 01420
Tel: (978) 878-8100
Fax: (978) 878-8498

Greater Gardner Community Health Center
175 Connors St., Gardner, MA 01440
Tel: (978) 878-8100
Fax: (978) 410-6109

Leominster Community Health Center
14 Manning Ave., Leominster, MA 01453
Tel: (978) 878-8100
Fax: (978) 847-0112

ACTION
Health Services
Tel: (978) 878-8110
Fax: (978) 878-8535

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PATIENT MEDICAL HISTORY:

Patient Name: _____ Date of Birth: _____ /_____ /_____

Do you have a physician? □ Yes □ No Physician Name: _____

Last Exam: _____ Office Phone Number: _____

Do you have a specialist? □ Yes □ No Specialist Name: _____

Reason: _____ Office Phone Number: _____

Please list all MEDICATIONS that you take (including over the counter): CHECK HERE IF NONE: □

NAME of medication	Strength/ Dosage	How often taken

Has your physician ever recommended that you pre-medicate with an antibiotic before dental treatment: Yes ☐ No ☐

If yes, please tell us the reason for pre-med and which antibiotic you take: _____

Please list any SURGERIES, HOSPITALIZATIONS, SERIOUS ILLNESSES you have had in the past 5 years: CHECK HERE IF NONE: □

Surgery /Hospitalization / Illness	Month/Year

Please list any ALLERGIES you have: CHECK HERE IF NONE: □

Allergy	Reaction

Habits:

Tobacco (smoking, chew, e-cigarettes – Note amount per day)	YES NO
Alcohol (# drinks/ type per day)	YES NO
Caffeine (cups per day)	YES NO
Street Drugs (type)	YES NO

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PATIENT MEDICAL HISTORY CONT'D :

Patient Name: _____ Date of Birth: _____/_____/_____

Women Only:

Are you Pregnant? If yes – how far along?	YES NO	
Are you nursing?	YES NO	
Are you taking/using any type of birth control? If YES - what do you take/use?	YES NO	

Please CIRCLE YES OR NO (to the right) if you currently have or have had a history of the following:

Cardiac Pacemaker – If YES, Date Placed:	YES NO	AIDS/ HIV Infections	YES NO
Heart Attack – If YES, Date:	YES NO	Hepatitis – A, B or C	YES NO
Mitral Valve Prolapse If YES, is there regurgitation?	YES NO	Liver Disease	YES NO
Angina	YES NO	Kidney Disease	YES NO
High Blood Pressure	YES NO	Cancer	YES NO
Low Blood Pressure	YES NO	Leukemia	YES NO
Stroke	YES NO	Radiation / Chemo Therapy	YES NO
Epilepsy / Seizures	YES NO	Alzheimer's / Dementia	YES NO
Diabetes	YES NO	ADHD	YES NO
Arthritis	YES NO	Intellectual Disability	YES NO
Joint Replacement – If YES, is PRE-MED Required?	YES NO	Autism/ Aspergers	YES NO
Thyroid Problem – Hypo or Hyper	YES NO	Mental Illness	YES NO
Stomach Ulcers / Acid Reflux	YES NO	Rheumatic Fever	YES NO
Glaucoma	YES NO	Use of Fen-Phen medication	YES NO
Respiratory Problems (Emphysema, COPD, etc)	YES NO	Use of Bisphosphonates (Fosamax,Boniva, Actonel)	YES NO
Asthma	YES NO	Use of Viagra within 24 hours	YES NO
Anemia	YES NO	Other:	

Patient Dental History:

Please CIRCLE YES OR NO (to the right) if you currently have or have had a history of the following:

Pain to any of your teeth	YES NO	Bleeding gums while brushing or flossing	YES NO
Frequent headaches	YES NO	Sensitivity to hot, cold, or sweets	YES NO
Difficulty in chewing	YES NO	Orthodontic treatment (Braces)	YES NO
Pain (join, ear, side of face)	YES NO	Endodontic treatment (Root Canal)	YES NO
Head, neck or jaw injuries	YES NO	Prolonged bleeding following extractions	YES NO
Clenching or grinding teeth	YES NO	Difficult extractions	YES NO
Biting of lips or cheeks frequently	YES NO	Wear dentures or partials	YES NO
Difficulty in opening or closing	YES NO	Do you like your smile?	YES NO
Clicking or popping when opening/closing	YES NO	Received Oral hygiene instructions regarding the care of your teeth and gums.	YES NO
Sores or lumps in or near your mouth, face or neck	YES NO	Other:	

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Patient Name: _____ Date of Birth: _____/_____/_____

Dental Consent for Treatment

I, _____, DOB: _____ certify that I have read and understand the above information to the best of my knowledge. I have accurately answered the above questions in the medical and dental history questionnaire. I understand that providing insufficient or incorrect information can be dangerous to my (or the person under my care for which I am the legal guardian) health.

I hereby authorize Community Health Connections dental service and its licensed providers to treat me or the person under my care (I am the legal guardian) with the following dental procedures (if/when needed): prophylaxis (dental cleaning), restorations (fillings), non-surgical treatment of gums, all emergency services and any other treatment the dentist considers necessary to create better oral and overall health.

X Signature: _____ Date: _____

CHC Provider Signature: _____ Date: _____

Dental Authorization and Release

I, _____, DOB:_____hereby authorize Community Health Connections Dental Service and its licensed providers to treat me (or the person under my care for which I am the legal guardian) with dental treatment, and / or dental procedures as recommended by my dental providers after discussion with me.

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me (or the person under my care for which I am the legal guardian) during the period of such dental care to third party payors and/or health practitioners including the Community Health Connections Behavioral Health and Medical departments as needed for coordination of my care.

I authorize and request the insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

X Signature: _____ Date: _____

CHC Provider Signature: _____ Date: _____

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