WENTWORTH HEALTH PARTNERS

Community Dental Center

Patient Registration Form

Full Version – Use For New Patients/Initial Visit

Preferred language to discuss your care: _____

Would you like an interpreter? □ No □ Yes (Language _____)
Check if any of the following apply: □ Deaf/Hard of Hearing □ Visually Impaired □ N/A

Preferred Learning style(s) - □ Reading (visual) □ Hearing (verbal) □ Demonstration

Patient Information

Name:_____ Date of Birth: _____ Social Security Number: _____
Sex: □ Male Female Mother's Maiden Name: _____
Street Address: _____ City, State, Zip:_____
Mailing Address:_____ City, State, Zip: _____
Marital Status: (**Please check one**) □Single □Married □Divorced □Separated □Widow(er)
Home Phone # (____)_____ Work # (____)_____ Cell # (____)_____

What is the preferred number at which to reach you? □ Home □ Work □ Cell
For cell phones, do you have text capability? □Yes □ No
How did you hear about our practice? _____
Primary Care Provider: _____ Practice Name _____
If PCP and/or Practice is part of Wentworth Health Partners – this practice may query electronic medical record regarding your current medications and/or status of any controlled substance agreements.

Emergency Contact: Used Only If Unable To Reach You - No Health Information Will Be Shared

Name: _____ Phone: # (___) _____ Relationship to Patient:_____

Parent/Legal Guardian (If patient is under 18 or over 18 and unable to make decisions for him/herself)

Name of Parent/Guardian 1: _____ Name of Parent/Guardian 2:_____
Street Address _____ Street Address _____
Mailing Address _____ Mailing Address _____
City, State, Zip _____ City, State, Zip _____
Date of Birth _____ Date of Birth _____
Best phone # to reach you (_____) _____ Best phone # to reach you (_____) _____
Relationship to Patient _____ Relationship to Patient _____

□ Married □ Divorced □ Separated □ Not Married □ Civil Union

(Please provide a copy of relevant court documents if you claim sole legal custody of a minor or are the legal guardian for patient over 18.)

Patient Name_____Date of Birth _____

Primary Insurance Name_____
Name of Subscriber _____
Subscriber's Address If Different From Patient's:
_____
Subscriber's Date of Birth _____
Relationship to Patient _____
Employer _____

Secondary Insurance Name_____
Name of Subscriber _____
Subscriber's Address If Different From Patient's:
_____
Subscriber's Date of Birth _____
Relationship to Patient _____
Employer _____

Race (Please Check One)
☐American Indian or Alaskan Native
☐Asian
☐Black or African American
☐Hispanic
☐Indian
☐Multi-Racial
☐Native Hawaiian or Other Pacific Islander
☐White
☐Unknown/Unavailable
☐**Decline**

Ethnicity (Please Check One)
☐Hispanic or Latino
☐Not Hispanic or Latino
☐Unknown/Not Reported
☐Unavailable
☐**Decline**

Language (Please Check One) or ☐Decline

☐English	☐Gujarati	☐Khmer	☐Panjabi	☐Tai (Other)
☐Arabic	☐Hebrew	☐Khotanese	☐Persian	☐Tamil
☐Balinese	☐Hindi	☐Korean	☐Philippine (Other)	☐Telugu
☐Bengali	☐Hungarian	☐Lao	☐Polish	☐Tagalog
☐Bosnian	☐Igbo	☐Lushai	☐Portuguese	☐Thai
☐Bulgarian	☐Igala	☐Malayalam	☐Provencal	☐Turkish
☐Burmese	☐Indonesian	☐Marathi	☐Romani	☐Urdu
☐Chinese	☐Indo-European	☐Mandar	☐Romanian	☐Vai
☐Chamic Languages		☐Minangkabau	☐Russian	☐Vietnamese
☐Dutch	☐Italian	☐Neopolitan Italian	☐Sign Languages	☐Unknown
☐French	☐Japanese	☐Nepali	☐Spanish	
☐German	☐Kamba	☐Nyoro	☐Swahili	
☐Greek	☐Kabardian	☐Old Norse	☐Swedish	

☐Other: _____

Patient Name_____Date of Birth _____

Advance Directive is a legal document with instructions you give regarding your future care if you are unable to make decisions about your care.
There are two sections; you may have completed one or both of the sections:

1. *Durable Power of Attorney for Health Care (DPOAH)* - you name another individual to make healthcare decisions for you when you are unable to. Your provider determines that you can no longer make decisions for yourself and activates the DPOAH.
2. *Living Will* - you instruct your health care provider to give no life-sustaining treatment if you are near death or are permanently unconscious, with no hope for recovery.

Do you have an Advance Directive?	□ Yes	□ No	If Yes, **please provide us a copy**.
Do you only have a Living Will?	□ Yes	□ No	If Yes, **please provide us a copy**.
Do you only have a Durable Power of Attorney for health care?	□ Yes	□ No	If Yes, **please provide us a copy**.
Do you have a Durable General Power of Attorney for finances?	□ Yes	□ No	If Yes, **please provide us a copy**.

If you answered No to any of the above, **please ask us for an information packet**.

Financial Assistance
If you require financial assistance to enable you to afford the health care that you need, please ask any staff member and they will provide you with a WDH Financial Assistance Application and a copy of the Financial Assistance Policy. For questions regarding Financial Assistance, please call (603)740−3342.

Insurance Authorization and Assignment of Benefits
I authorize and assign insurance benefit payment directly to the practice for any dental services I receive. I understand and agree that I am ultimately responsible for the charges on my account for any professional services rendered. I will be responsible for payment in full of all balances not paid by my insurance company. In an effort to help ensure accurate insurance billing, we ask that you present your insurance card and photo ID at each visit. Acceptable forms of payment are cash, check, and credit card (MasterCard, Visa, and Discover).

Partners HealthCare Notice of Privacy Practices
I have received/was offered a copy of the Partners HealthCare Notice of Privacy Practices. The Partners HealthCare Notice of Privacy Practices describes how my health information may be used or disclosed and explains my rights as a patient. I understand that I should read this document carefully and that it may be changed at any time. I may obtain a copy of the Partners HealthCare Notice of Privacy Practices by calling the practice. This practice uses an electronic medical record that is shared with Wentworth-Douglass Hospital and other affiliated practices.

I consent to evaluation and treatment by any provider affiliated with WHP. I hereby authorize release of medical information that is necessary for my further treatment and for the purpose described in the Partners HealthCare Notice of Privacy Practices.

Patient Name or Legal Guardian (please print) _____

Patient or Legal Guardian Signature_____ Date _____

COMMUNITY DENTAL CENTER

Practice Policies

- We require 24 hour notice if you are unable to keep a scheduled appointment. If you miss an appointment we will notify you by mail. Any patient with **3 broken/missed appointments** within a 12 month period **may be discharged from the Dental Center.**
- Your dental health is important – and we encourage you to call the practice to reschedule appointments or if you have questions.
- Any patient that arrives more than 10 minutes late – may not be seen and this will be considered a broken appointment.
- Drug and Alcohol Use – patients should be aware that using drugs or alcohol prior to a dental appointment can be dangerous. Any patient under the influence of either drugs or alcohol will be rescheduled.
- Patients are expected to:
    - Treat staff with respect and dignity.
    - Speak politely and in a calm tone of voice.
    - Refrain from using foul language both on the phone and in the office.
    - Parents must control their children at all times.
    - Be honest with us regarding your concerns – there are no silly questions.

- I agree to pay the $35.00 visit fee for all visits. I understand that the balance of the cost of treatment is subsidized by the financial assistance awarded to me through the Wentworth-Douglass Hospital. If I am covered by either MaineCare or Medicaid – and coverage is active at the time of service – the $35.00 visit fee is waived.

- I understand that the following services have a separate fee schedule and understand these are the subsidized fees. I agree to pay as follows:
    - Dentures (full or partial)
    - Crowns (very limited)

Patient Name: _____ DOB: _____

_____ _____

Patient or Parent/Guardian Signature Date