

Community Kids Dental69 Allen Street, Suite 7
Rutland, VT 05701
802-772-4413**Community Dental Rutland**69 Allen Street, Suite 10
Rutland, VT 05701
802-774-5050**DENTAL
COMMUNITY
HEALTH**

MEDICAL • DENTAL • BEHAVIORAL HEALTH

Community Dental Shorewell2987 Route 22A
Shoreham, VT 05770
802-897-7716**REGISTRATION FORM**

| | | | | | | | |
|--|--|--------------------------|--------------------|---------------------------------------|-----------------|-----------------|---|
| Patient's last name: | | First: | | Middle Initial: | | Marital Status: | |
| Preferred Name: | | Former Name: | | | Birth date: | | Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Mailing Address: | | | | | | | |
| Social Security No.: | | Home Phone No.: | | | Cell Phone No.: | | |
| Email: | | | | | Work Phone No.: | | |
| Pharmacy: | | | Pharmacy Location: | | | | |
| INSURANCE INFORMATION | | | | | | | |
| Person responsible for bill: | | | | Birth date: | | Home Phone No.: | |
| Address (if different): | | | | | | | |
| Name of primary insurance: | | | | Subscriber's Name: | | | |
| Subscriber's S.S. No.: | | Subscriber's Birth date: | | Patient's Relationship to Subscriber: | | | |
| Policy No.: | | Group No.: | | | Co-payment: | | |
| Name of secondary insurance (if applicable): | | | | Subscriber's Name: | | | |
| Subscriber's S.S. No.: | | Subscriber's Birth date: | | Patient's Relationship to Subscriber: | | | |
| Policy No.: | | Group No.: | | | Co-payment: | | |
| IN CASE OF EMERGENCY | | | | | | | |
| Name of local friend or relative: | | | | Relationship to Patient: | | Phone No.: | |
| I give my permission for my Dental Care Provider at Community Health to discuss my dental condition and/or test results with: | | | | | | | |
| Name: | | | | Relationship: | | | |
| Street Address: | | | | City: | | State: | Zip: |
| Phone No.: | | | | | | | |
| <p>*Please provide us with your insurance cards so that we may make a copy for our records.</p> <p>I authorize the release of information, including the diagnosis and copies of records of any treatment or examination rendered to me or my dependent during the period of such care, to third party payers and/or other health practitioners. I agree that this consent constitutes any permission that Community Health dental staff would otherwise be required to obtain under Vermont laws before so using or disclosing my protected health information. I am aware that Community Health privacy practices are further described in the Community Health Notice of Privacy Practices. I give my consent for examination, diagnostic procedures, dental treatments and surgical procedures including local anesthesia, as prescribed by my dentist. I acknowledge that no guarantees have been made to me regarding the results of the examination and/or treatment. I authorize and request my insurance company to pay directly to Community Health, benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf, or my dependents in accordance with my health care plan.</p> <p>I understand that this form gives permission for treatment in accordance with the dentist's orders. For the purpose of advancing dental education, I authorize the attendance of students participating in Community Health programs. I authorize Community Health to examine, retain, and preserve or dispose of any tissues or specimens removed from my body. I authorize my insurance company or employer to discuss matters related to the payment of claims with Community Health.</p> | | | | | | | |

Signature of Patient/Parent/Guardian_____
Date

Patient name: _____ Patient date of birth: _____ Account#: _____

Please answer all questions on this page. As a Health Center that receives federal funding, we are required to collect this information. Our funding makes sure we can serve anyone who needs our care. All answers are confidential. We appreciate your help!

Race: African-American Asian-American Caucasian/White Native American Pacific Islander
 Multi-Racial Other _____

Are you a Veteran? Yes No **Ethnicity:** Hispanic Non-Hispanic

Primary Language: English Spanish American Sign Other _____

Do you need an Interpreter? Yes No Language: _____

Are you homeless? Yes No If homeless are you: Living with others Shelter Street Transitional

Answer the following 2 questions if you are over 18:

Patients Sexual Orientation: Lesbian or gay Straight or Heterosexual Bisexual Something else
 Don't know Chose not to disclose

Patients Gender Identity: Male Female Transgender Male/Female-to-male Transgender
 Female/Male-to-female Other Chose not to disclose

Family Financial Information Please circle your family size and household income range below:
 Chose not to disclose

**Self-Pay Sliding Fee Schedule
 2022 Poverty Level Guidelines
 ANNUAL INCOME**

| Household Size | 100% Discount \$10 Medical Fee | 90% Discount \$20 Medical Fee plus 10% balance billed | 80% Discount \$20 Medical Fee plus 20% balance billed | 70% Discount \$20 Medical Fee plus 30% balance billed |
|--|--|--|--|--|
| | Full Subsidy | 101-135% | 136-170% | 171-200% |
| 1 | \$0- \$13,590 | \$13,591- \$18,347 | \$18,348- \$23,104 | \$23,105- \$27,180 |
| 2 | \$0- \$18,310 | \$18,311- \$24,719 | \$24,720- \$30,588 | \$30,589- \$36,620 |
| 3 | \$0- \$23,030 | \$23,031- \$31,091 | \$31,092- \$39,152 | \$39,153- \$46,060 |
| 4 | \$0- \$27,750 | \$27,751- \$37,463 | \$37,464- \$47,176 | \$47,177- \$55,500 |
| 5 | \$0- \$32,470 | \$32,471- \$43,835 | \$43,836- \$55,200 | \$55,201- \$64,940 |
| 6 | \$0- \$37,190 | \$37,191- \$50,207 | \$50,208- \$63,224 | \$63,225- \$74,380 |
| 7 | \$0- \$41,910 | \$41,911- \$56,579 | \$56,580- \$71,248 | \$71,249- \$83,820 |
| 8 | \$0- \$46,630 | \$46,631- \$62,951 | \$62,952- \$79,272 | \$79,273- \$93,260 |
| <i>For each additional person, add</i> | \$4,720 | \$4,720 | \$4,720 | \$4,720 |

*You may qualify for discounted medical care based on your answers above. Please ask the office staff for more information.