Introduction to the IHC Dental Center

Pediatric New Patient Packet

Thank you so much for your interest in becoming a new dental patient at Island Health Care! We are excited to have you join our practice.

Please bring this completed packet to the Island Health Care Clinic at 245 Edgartown Vineyard Haven Road. Please also bring the following items if you have them:

- **Photo ID**
- **Insurance card (enter details below)**

Primary Dental Insurance (e.g., MassHealth, BCBS, Delta Dental)	**Subscriber Name**
Subscriber's Relationship to Patient	**Subscriber Date of Birth** (MM/DD/YYYY)
Subscriber Social Security Number (SSN)	**Do you have secondary insurance?** *If yes, please provide information to the front desk* ❑ Yes ❑ No
Subscriber ID Number	

If you have a primary care provider, please include that information here:

Primary Care Provider Name	**Primary Care Provider Phone Number**

Important Notes:

- After dropping off your completed new patient paperwork, we will contact you in the order your packet was received to schedule your appointment.
- We will make **three attempts** to reach you by phone call and text message. If your voicemail identifies you by name, we will leave a message. **Please notify us promptly if your phone number changes.**
- If we are unable to reach you after three attempts, please call us at 508-939-9358 to schedule.
- **Sign Up for MyChart!** MyChart is IHC's patient portal, powered by Epic. Through the app or website, you and your caregivers can message your care team, request refills, view test results and records, and pay bills. During registration, we'll invite you to create an account—we strongly encourage all patients to do so. Questions? Just ask!

In addition to dental care, do you need a Primary Care Provider (PCP) for your medical care? *If yes, Island Health Care will contact you to schedule a Primary Care appointment.*	❑ Yes ❑ No

Patient Registration

Medical Record #
For office use only

Island Health Care

We are committed to safeguarding your privacy and ensuring that your personal information is handled with care and respect. Demographic information is used to tailor our services and programs to better meet your individual needs and preferences and will never be used to discriminate against or stigmatize any individual or group.

Legal Name (Print) Last	First	Middle Initial	**Name Used** (if different)
Date of Birth (Month / Day / Year)	**Social Security Number**		

Contact Information

Your answers to the following questions will help us reach you quickly and discreetly with important information.

Home Phone ❑ OK to leave voicemail	**Patient Cell Phone** (if 12 or older) ❑ OK to leave voicemail	**Parent Cell Phone** ❑ OK to leave voicemail	Best Number to reach you ❑ Home ❑ Cell
Mailing Address (P.O. Box if you have one)		City	State / Zip Code
Physical Address		City	State / Zip Code
Patient's Email Address (if 12 or older for MyChart access)		**Are you a student?** ❑ Full-time ❑ Part-time ❑ Not a student	
Parent / Guardian 1	Phone	Relationship to Patient	Communications preferences* ❑ Phone ❑ Email ❑ Text ❑ Mail ❑ MyChart
**Select all that apply. By choosing these communication preferences, you are giving Island Health Care permission to contact you using the selected methods.*			
Parent / Guardian 1 Mailing Address		City	State / Zip Code
Parent / Guardian 2	Phone	Relationship to Patient	Communications preferences* ❑ Phone ❑ Email ❑ Text ❑ Mail ❑ MyChart
**Select all that apply. By choosing these communication preferences, you are giving Island Health Care permission to contact you using the selected methods.*			
Parent / Guardian 2 Mailing Address		City	State / Zip Code

In which language do you feel most comfortable reading medical or health care instructions?	**In which language do you feel most comfortable speaking with your doctor or nurse?**
❑ English ❑ Português ❑ Other:_____ ❑ Español ❑ ASL ❑ Choose not to disclose	❑ English ❑ Português ❑ Other:_____ ❑ Español ❑ ASL ❑ Choose not to disclose

Do you need any language accommodations or support to help us understand each other better?
❑ Yes ❑ No

Patient Registration

Island Health Care

This information is for demographic purposes only, without personal identifiers and does not affect your care.

1a. What is your annual income?

$ _____

- ☐ No income

1b. How many people does your income support?

_____

2. Veteran status

- ☐ Veteran of U.S. Military
- ☐ Not a veteran of U.S. Military
- ☐ Currently serving
- ☐ Choose not to disclose

3. Do you work in healthcare?

- ☐ Yes
- ☐ No

4. Do you live in congregate housing?

(E.g., nursing home, assisted living facility, etc.)

- ☐ Yes
- ☐ No

5. Race

Check all that apply

- ☐ Alaska Native
- ☐ Black / African American
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian / Chamorro
- ☐ Indian
- ☐ Japanese
- ☐ Korean
- ☐ Native American
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ I don't know/ am not sure of my race
- ☐ I choose not to answer

6. Ethnicity

- ☐ Cuban
- ☐ Mexican, Mexican American, or Chicano/a
- ☐ Puerto Rican
- ☐ Other Hispanic or Latino/a
- ☐ Not Hispanic or Latino/a
- ☐ I don't know/am not sure of my ethnicity
- ☐ I choose not to answer

7a. Are you homeless or unhoused?

- ☐ Yes
- ☐ No

If no, skip to question 8

7b. Housing status

Only answer if you selected "yes" on question 7a

- ☐ Living in transitional housing
- ☐ Doubling up (ex. sharing a single space with others)
- ☐ Living in homeless shelter
- ☐ Living in permanent supportive housing
- ☐ Living in woods / car / camping / street
- ☐ Unknown housing location
- ☐ Other: _____

8. What is your gender?

- ☐ Female
- ☐ Male
- ☐ Agender
- ☐ Gender expansive
- ☐ Gender fluid
- ☐ Gender non-conforming
- ☐ Gender queer
- ☐ Intersex
- ☐ Non-binary
- ☐ Transfeminine
- ☐ Trans female
- ☐ Trans male
- ☐ Transmasculine
- ☐ Two spirit
- ☐ Choose not to answer
- ☐ I'm not sure/ don't know my gender identity
- ☐ My gender identity is not listed

9. What was your sex assigned at birth?

- ☐ Female
- ☐ Male
- ☐ Not recorded on birth certificate
- ☐ Uncertain
- ☐ I choose not to answer
- ☐ Other

10. What is your legal sex?

- ☐ Female
- ☐ Male
- ☐ Non-binary
- ☐ Other

11. Do you think of yourself as:

- ☐ Aromantic
- ☐ Asexual
- ☐ Bisexual
- ☐ Demisexual
- ☐ Gay
- ☐ Lesbian
- ☐ Lesbian or Gay
- ☐ Pansexual
- ☐ Queer
- ☐ Straight / heterosexual
- ☐ Something else
- ☐ Don't know
- ☐ I choose not to answer

12. Marital status

- ☐ N/A - I'm under 18
- ☐ Divorced
- ☐ Domestic partner
- ☐ Legally separated
- ☐ Life partner
- ☐ Married
- ☐ Significant other
- ☐ Single
- ☐ Widowed
- ☐ Other: _____
- ☐ I choose not to answer

13. What are your pronouns?

- ☐ She / her / hers
- ☐ He / him / his
- ☐ They / them / theirs
- ☐ My name
- ☐ I choose not to answer
- ☐ My pronouns are not listed

14a. Are you a seasonal farm worker?

- ☐ Yes
- ☐ No

14b. Farm worker status

- ☐ Migratory agricultural worker during the last 2 yrs
- ☐ Seasonal agricultural worker during the last 2 years
- ☐ Neither

15. Referral source

How did you hear about us?

- ☐ Social Media (ex. Facebook, Instagram)
- ☐ Internet search
- ☐ Friend or family member
- ☐ Health provider
- ☐ Emergency room
- ☐ Newspaper ad or article
- ☐ Outreach worker
- ☐ School
- ☐ Other: _____

Collaboration/Record Sharing with Other Healthcare Providers Involved in Your Care

Island Health Care

Care Everywhere is a tool that enables the exchange of patient health information across different healthcare organizations and systems, even if they are using different electronic health record (EHR) platforms. The goal of Care Everywhere is to improve patient care by ensuring that a complete picture of the patient's medical history is accessible, regardless of where the patient has previously received care. It also helps reduce errors or delays due to missing or incomplete information. Here's a brief overview of Care Everywhere's functionality:

1. Care Everywhere allows healthcare providers to access and share a patient's health records across different systems. For example, if a patient visits a healthcare facility that uses Epic and then visits a different facility that uses a different EHR system, Care Everywhere helps exchange the relevant health data, ensuring that healthcare providers have comprehensive information to make informed decisions.
2. Through Care Everywhere, clinical data such as medications, allergies, lab results, immunizations, and diagnostic information can be securely shared between different Epic users or between Epic and non-Epic systems. This can improve care coordination, reduce duplicate tests, and support better patient outcomes.
3. Care Everywhere provides alerts to clinicians when a patient's data has been updated or when there are new records from external sources. This ensures that the care team stays informed about any important changes to the patient's health history.

Your Rights and Responsibilities:

- You have the right to refuse consent to the sharing of your health information through Care Everywhere. If you refuse, this applies to your entire electronic health record. If you'd like to refuse consent, please let the front desk know so that they can give you a declination form.
- You have the right to withdraw your consent at any time, and the withdrawal will apply to future information exchanges.
- Withdrawal of consent will not affect the use or disclosure of your health information prior to the withdrawal date.

Epic's Care Everywhere system uses strict security protocols to ensure the privacy and safety of your health information. Only authorized healthcare providers will have access to your data, and all exchanges are governed by healthcare privacy laws, including HIPAA (Health Insurance Portability and Accountability Act).

By signing below, I acknowledge that I understand how my or my dependent/child's health information may be shared through Care Everywhere.

Name of Patient	**Patient's Date of Birth**
Signature of Patient / Guardian	**Today's Date**
Name of Guardian (If signing on the patient's behalf)	**Relationship to Patient** (if signing on patient's behalf)

Proxy Consent to Treat Minors

Island Health Care

This form may be used to allow an adult other than a parent or legal guardian to serve as a proxy decision maker for routine medical and dental care and services at Island Health Care (IHC). For some families, it may be more convenient to have prior authorization in place that allows routine medical and dental care to be delivered to minors under the care of a proxy decision maker if a parent or legal guardian cannot be present to provide consent or to accompany the minor. If you would like to appoint a proxy decision maker, please review and complete the following form.

Authorization: I hereby appoint the below-named individual as a proxy decision maker to consent to and authorize routine health care, treatment and services for my child(ren) listed below.

Name (Print)	Relationship	Best Phone Number

Routine medical and dental care and interventions may include, but are not limited to: medical evaluation, physical exam, x-rays, lab work (examples include: throat or nasal swabs, blood draws, wart treatment with liquid nitrogen, cleaning of minor burns, minor suturing of lacerations, removal of simple cysts, contraceptive care, and incision and drainage of abscesses); dental examination, cleaning, fillings, extractions, and other routine dental procedures. IHC may also give immunizations, allergy shots and intramuscular/intravenous antibiotics pursuant to the consent of the proxy.

I hereby empower and grant the proxy decision maker appointed above permission to consent to and authorize routine medical and dental care as may be deemed necessary or advisable in the diagnosis and treatment of the minor child(ren) listed below, and to receive protected health information directly relevant to and for the purposes of his or her involvement in this care or payment related to this care. More than one child may be listed.

Name of Minor	**Minor's Date of Birth** (MM/DD/YYYY)
Name of Minor 2	**Minor's Date of Birth** (MM/DD/YYYY)
Identify any specific limitations on the kinds of medical and dental services for which this authorization is given (if none, specify "none").	**Limitations**

The authorization is valid for (check one):

- ❑ Today's visit only
- ❑ From _____/_____/_____ to _____/_____/_____ (MM/DD/YYYY)
- ❑ Until revoked in writing by me

I hereby indemnify and hold harmless Island Health, Inc. and all its officers, agents, employees, attorneys, directors, insurers, affiliates, subsidiaries, related corporations, successors, heirs and assigns from any and all liability for acting in reliance on this authorization. The individual appointed as proxy (listed above) is permitted to make decisions on consent to the care in my absence. I also agree to accept financial responsibility for all care and services delivered pursuant to this authorization.

Full Name (Print)	**Signature**	**Today's Date**

Authorization to Treat Unaccompanied Minor

Island Health Care

Minor patients between the ages of 14 and 18 may be seen by their Island Health Care provider for medical or dental care even if they are not accompanied by a parent, legal guardian, or designated proxy, so long as their parent or legal guardian has completed this form.

Patient's Name (Print)	**Patient's Date of Birth** (MM/DD/YYYY)

I, the undersigned, hereby authorize Island Health Care providers and clinical staff to administer such medical and dental treatment as is necessary for the above-named patient. I hereby certify that I have read and fully understand this authorization.

The authorization is valid for (check one):

- ❑ Today's visit only
- ❑ From _____/_____/_____ to _____/_____/_____ (MM/DD/YYYY)
- ❑ Until revoked in writing by me

By default, this consent will be valid for one year from today's date unless otherwise specified above.

I understand that it is my responsibility to ensure payment for the care and services my minor child receives from Island Health Care. I understand that I will be responsible for the payment of any and all services rendered, whether or not I have verified my care benefits with my insurance company. I hereby indemnify and hold harmless Island Health, Inc. and all its officers, agents, employees, attorneys, directors, insurers, affiliates, subsidiaries, related corporations, successors, heirs and assigns from any and all liability for acting in reliance on this authorization.

Parent or Legal Guardian Name (Print)
Parent or Legal Guardian Signature
Today's Date (Month / Day / Year)

Informed Consent for General Dental Procedures

Island Health Care

You, the patient or guardian, have the right to accept or decline dental treatment recommended by your dental provider or choose from alternate recommendations that meet the standard of care. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dental provider and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dental provider with accurate information before, during, and after treatment. It is equally important that you follow your dental provider's advice and recommendations regarding medication, pre- and post-treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice or recommendations, you may increase the chances of a poor outcome.

I agree to the following general treatment that may be included in my care or care of my dependent/child:

- **General Dental Treatment:** Examinations of head, neck, face, and mouth
- Dental x-rays (radiographs) and pictures
- Oral cancer screenings and counseling
- Oral health instructions
- Diet counseling
- Cleaning teeth and gums (prophylaxis)
- Applying fluoride and/or sealants
- Silver or white fillings (amalgam, composite, glass ionomer, or other types)
- Numbing medication (local anesthesia)
- Other medications to treat or prevent oral disease

Drugs and medications: I understand that antibiotics, analgesics and other medications may cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock. I have disclosed any and all medications I am currently taking, including but not limited to prescription medications, over-the-counter medications, herbal remedies, and alternative medications. I understand that a complete and accurate medical history is important for me to receive the highest quality and safest dental care.

Local anesthesia: I understand that local anesthesia carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia.

Fillings: To avoid damage, I understand that care must be taken when chewing on fillings, especially during the first 24 hours. I understand that a more extensive filling than originally planned may be required due to additional decay or problems found during the procedure. I understand that increased sensitivity is a common side effect of a newly placed filling.

Changes in treatment plan: I understand that during treatment, it may be necessary to change or add procedures because of conditions found that were not previously discoverable. These changes will be discussed with me and I will have the opportunity to verbally agree or decline the change in treatment, unless it is not practical due to a dental/medical emergency.

Cost of treatment: I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable. I understand that not all recommended treatment or costs may be covered by insurance and that the dental office

Informed Consent for General Dental Procedures

will make its best effort to provide me with cost estimates when that is the case. I allow Island Health Care to file for insurance benefits to pay for the care I receive. I understand that:

- Island Health Care will have to send my medical record information to my insurance company.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.*

MassHealth Dental Coverage Notice: I understand that MassHealth dental benefits may be subject to annual benefit limits, coverage restrictions, and claim denials. If services are not covered or if my available benefits have been exhausted, I may incur out-of-pocket expenses and agree to be responsible for any charges not paid by MassHealth.

Dental Externs: Island Health Care partners with Boston University's Henry M. Goldman School of Dental Medicine to support clinical training for dental students. As part of this program, you may receive care from an extern dentist (student dentist) who has completed substantial training at the School of Dental Medicine and is working toward graduation. All extern treatment is provided under the direct supervision of Dr. Aldino Maggiulli, an experienced, licensed dentist and BU faculty member; extern dentists are not licensed to practice independently. By signing below, you acknowledge that you have read and understand this information and consent to receive treatment from an extern dentist at the Island Health Care Dental Center.

Patient Rights and Privacy Practices:

- I understand that I have the right to request a copy of IHC's Notice of Patients' Rights and Patient Grievance Resolution process.
- I have had the change to review a copy of IHC's Notice of Privacy Practices, which describes how my health information is used and shared. I understand that Island Health Care has the right to change this Notice at any time. I may obtain a current copy by visiting the Island Health Care website at ihimv.org.

I consent to be treated by the dental providers at Island Health Care Dental Center. This consent shall be considered in effect until rescinded or revoked.

Name of Patient (Print)	**Patient Date of Birth**
Name of Representative (if signing on patient's behalf)	**Relationship to Patient** (if signing on patient's behalf)
Signature of Patient / Representative	**Date**

**Please ask the front desk about IHC's financial assistance programs if you are worried about the cost of your visit.*