OFFICE USE:
CHART NUMBER_____ STAFF INITIALS_____ TODAY'S DATE_____

Welcome to Dientes

We hope your visit with us is a pleasant experience.
Here's how our clinic works

Who we are: Dientes is a private non-profit organization. We are not a government clinic nor are we owned by a private dentist. A volunteer Board of Directors is responsible for the operation and funding of the clinic.

Our mission: To create lasting oral health for the underserved children and adults of Santa Cruz County and neighboring communities.

Who is eligible to use Dientes:

- Persons who have public insurance such as Medi/Denti-Cal, Healthy Families or Healthy Kids.
- Persons referred from special programs, such as the Homeless Persons Health Project, E.I.S, etc.
- Persons with low income. We define low income as persons with income no greater than twice the Federal Poverty Level. We will need proof of income, such as an income tax return, pay stub, unemployment check, disability determination, or social security check.

What we do*:* We provide basic dental services such as: examinations, x-rays, cleanings, sealants, fillings, crowns, dentures, extractions, some root canals, and emergency treatment. We do not provide: orthodontics, gum surgery, complex extractions or root canals, cosmetic dentistry. For these procedures we will refer you to specialists.

Terms of payment: Our policy is payment at the time of service. If we bill insurance and you have a co-pay which was not collected, we will invoice you for the remaining balance.

Our appointment policies: We see patients by appointment, like any other private office.

- We expect you to arrive on time or 10 minutes before.
- **It is the responsibility of the patient to confirm their appointment by 12:30 pm the day before the scheduled appointment**. We will attempt to give you a courtesy call to confirm.
- You may confirm your appointment during business hours or by message on our 24-hour voice mail.
- **Failure to confirm an appointment will result in the loss of your scheduled visit.**
- **If you miss two scheduled appointments (you fail to come OR cancel your appointment without giving proper notice) within a six-month period, you will be placed on a 6 month probation**. **If another appointment is missed while being on probation-you will be dismissed from the practice.**
- Children are not allowed to accompany a parent/adult to their appointment.

- ***Respect for each other:*** We are dedicated to providing high quality dentistry to you in a professional, courteous, and respectful manner. We expect you to treat our staff with the same courtesy and respect**. If these guidelines are not followed, we reserve the right to dismiss any patient from our practice. If you have any concerns about your dental treatment, you may submit your concern in writing and it will be addressed. We also have a patient satisfaction survey available for your feedback.**

I have read this sheet and understand how the Dientes clinic works.

_____ _____

Patient signature Date

WELCOME TO DIENTES

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely. The better communication, the better we can care for you.

PERSONAL INFORMATION

NAME: _____
Last First Middle

ADDRESS: _____
Street

_____
City State Zip

_____
Home Phone Cell Phone Message

_____ _____
Date of Birth Place of Birth (City & State)

_____ ☐ Male ☐ Female
Social Security Number

CA Driver's License: #_____

EMAIL ADDRESS: _____

INSURANCE INFORMATION

☐ **Denti-Cal ID #** _____

Please provide copy of your insurance card and picture ID.

☐ **EIP** ☐ **Homeless Project**

☐ **Other** _____

EMERGENCY INFORMATION

In case of emergency, whom should we call?

_____
Contact Name

_____
Relationship

_____
Phone

Preferred pharmacy_____

FULL PAYMENT IS EXPECTED AT THE TIME OF EACH APPOINTMENT.

How will you be paying today?

Cash_____ Check____ Credit Card_____

☐ **Denti-Cal ID #** _____

The following information is optional. Dientes Community Dental Care is a non-profit organization. We are asked to report the following information for a number of different grants, all of which enable us to continue to provide low-cost, quality dental care. ***We appreciate your willingness to answer the following questions****. Please ask the receptionist if you have questions.*

EMPLOYMENT

☐ Employer: _____

☐ Unemployed ☐ Veteran ☐ Agricultural Worker

ETHNICITY & LANGUAGE

☐ Caucasian (non-Hispanic)
☐ Hispanic or Latino
☐ African American
☐ Asian
☐ American Indian/Alaskan
☐ Native Hawaiian
☐ Pacific Islander
☐ Multi Racial
☐ Other

What is your primary language? _____

HOUSING STATUS

☐ Renting alone
☐ Renting with others
☐ Own home
☐ Staying with friends or family less than 6 months
☐ Renting a motel room
☐ Staying in a shelter
☐ Participating in transitional housing program
☐ Staying in your Car, Camping, or on the Street
☐ Skilled Nursing Facility

PATIENT REGISTRATION INFORMATION

DIENTES CONFIDENTIAL HEALTH HISTORY

Patient Name:_____ **Date of Birth**_____

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question.)

1 Yes No Is your general health good?
If NO, explain _____
2 Yes No Have you ever been hospitalized for operations or illness?
If YES, when and why? _____
3 Yes No Are you being treated by a physician now? If YES, why? _____
Date of last medical evaluation? _____ Reason: _____

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Check all that apply.)

☐ AIDS/HIV	☐ Fever	☐ Persistent cough
☐ Anemia	☐ Frequent urination	☐ Psychiatric care
☐ Arthritis, rheumatism	☐ Frequent vomiting	☐ Radiations
☐ Artificial joint	☐ Hardening of arteries	☐ Recent weight changes
☐ Asthma	☐ Headaches	☐ Rheumatic fever
☐ Bleeding problems	☐ Heart attack	☐ Ringing in ears
☐ Blood in stools	☐ Heart defects	☐ Seizures
☐ Blood in urine	☐ Heart disease	☐ Sexually transmitted disease
☐ Blurred vision	☐ Heart murmurs	☐ Shortness of breath
☐ Bruise easily	☐ Hepatitis	☐ Sinus problems
☐ Chemotherapy	☐ Herpes	☐ Skin disease
☐ Chest pain (Angina)	☐ High blood pressure	☐ Stomach problems or ulcers
☐ Coughing up blood	☐ Jaundice	☐ Stroke
☐ Diabetes	☐ Joint pain or stiffness	☐ Surgeries
☐ Difficulty swallowing	☐ Joint replacement	☐ Swollen ankles
☐ Difficulty urinating	☐ Kidney disease	☐ Thyroid disease
☐ Dizziness	☐ Liver disease	☐ Tuberculosis
☐ Eating disorders	☐ Lung disease	☐ Tumors or cancer
☐ Excessive thirst	☐ Night Sweats	☐ Family history of diabetes
☐ Eye disease	☐ Organ transplant	☐ Family history of heart disease
☐ Fainting spells	☐ Osteoporosis	☐ ***NONE***

Other conditions : _____

Is there any issue or condition that you would like to discuss with the dentist in private? **Yes** **No**

III. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Check all that apply.)

☐ Aspirin	☐ Antibiotics	☐ Food	☐ Latex
☐ Local anesthetic "Novacaine"	☐ Metals	☐ Pain Medication	☐ Acrylic
☐ Nitrous oxide	☐ Penicillin	☐ Sedatives	☐ ***No Known Drug Allergies***

If marked box or you have other allergies not listed, please explain: _____

IV. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (Check all that apply.)

Reviewed

☐ Alcohol	☐ Bisphosphonates	☐ Nitroglycerin	☐ Tobacco in any form
☐ Antibiotics	☐ Blood thinners	☐ Recreational drugs	☐ Weight loss medications
☐ Aspirin	☐ Digitalis	☐ Supplements	☐ ***NONE***

Yes No Have you ever taken Fen-phen? If YES, when? _____

Current Medications: _____

V. FOR WOMEN ONLY:

Is there a possiblity you may be pregnant?	Yes	No
Are you nursing?	Yes	No
Are you using oral contraceptives?	Yes	No

It is important to understand that antibiotics (and other medications) may interfere with the effectiveness of oral contraceptives. After consultation with your physician, alternatives to oral contraceptives may be needed while taking antibiotics.

DIENTES CONFIDENTIAL HEALTH HISTORY

VI. ORAL HEALTH QUESTIONS

What is the purpose for today's visit? _____

How are you feeling about your visit today? _____

When was your last visit to the dentist? _____ Where? _____

Have you ever had difficulty during dental treatment? If yes please explain. _____

Do you have dental anxiety? If yes, please explain. _____

What are the goals you have in seeking dental treatment? (Pain relief, maintain teeth, save teeth, extract damaged teeth, etc..)

_____

Have you had the following in the past year?

☐ Dental X-rays ☐ Dental Cleaning ☐ Other dental treatment

Do you currently have or have you had any of the following?

☐ Sensitive teeth	☐ Major head injuries	☐ Dry mouth	☐ Difficulty opening or closing
☐ Bleeding or hurting gums	☐ Difficulty Chewing	☐ Gum Disease	☐ Bad breath/mouth odor
☐ Jaw or tooth pain	☐ Deep cleaning	☐ Dental Surgery	☐ Wisdom teeth removal
☐ Braces/Orthodontics	☐ Clinching/grinding		

Please explain any marked conditions: _____ _____

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician:

Patient's Signature:_____ Date:_____

Physician's Name:_____ Phone number:_____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent or Guardian) **Date** **Signature of Dentist** **Date**

dientes
COMMUNITY DENTAL

PLEASE READ & SIGN BELOW

Acknowledgement of Receipt of Notice of Privacy Practices

I, ____ have received a copy of this office's Notice of Privacy Practices.

______________________________ ________________
Signature Date

- -

Patient Acknowledgement of Receipt of Dental Materials Fact Sheet

I, ____ acknowledge that I have received a copy of the Dental Materials Fact Sheet dated May 2004 from Dientes Community Dental Clinic.

______________________________ ________________
Signature Date

- -

Photo Release:

I hearby authorize and give full consent to Dientes Community Dental Clinic to photograph/video myself or my child and copyright, reproduce and publish these photographic images for any and all publications, displays, and advertising purposes, without limitation or reservation or any compensation other than that receipt of which is hereby acknowledged.

____ YES, I agree **____ NO, I decline**

________________________________ ____________________

Signature Date