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.
- Persons with private insurance are NOT eligible to be patients of Dientes.

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, root canals, or cosmetic dentistry. For these procedures we will refer you to specialists.

Terms of payment: Our policy is payments or co-pays are expected at the time of service.

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 no later than 12:30pm 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 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

Last updated 3/24/2014
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)

Social Security Number

CA Driver’s License: #_______________________

EMAIL ADDRESS: ________________________________

*Please provide copy of your insurance card and picture ID.

Denti-Cal ID # ___________________________

Denti-Cal ID # ___________________________

FULL PAYMENT IS EXPECTED AT THE TIME OF EACH APPOINTMENT.
How will you be paying today?
Cash____    Check____    Credit Card____

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.

EMERGENCY INFORMATION

In case of emergency, whom should we call?

Contact Name

Relationship

Phone

Preferred pharmacy_________________________

INSURANCE INFORMATION

□ Denti-Cal ID # ___________________________

□ EIP□ Homeless Project

□ Other __________________________

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

EMPLOYMENT

□ Employer: ___________________________

□ Unemployed □ Veteran □ Agricultural Worker

ETHNICITY & LANGUAGE

□ Caucasian (non-Hispanic) □ Native Hawaiian
□ Hispanic or Latino □ Pacific Islander
□ African American □ Multi Racial
□ Asian □ Other

□ American Indian/Alaskan
What is your primary language? ___________________________

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.)

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

Reviewed

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

Current Medications: ________________________________

V. FOR WOMEN ONLY:

Is there a possibility 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.
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 ☐ Deep cleaning ☐ Wisdom teeth removal
☐ Braces/Orthodontics ☐ Clinching/grinding ☐ Dental Surgery ☐

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 __________________________
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 hereby 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