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 benefit 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.

### PATIENT INFORMATION

| NAME: | ____________________________ |
| Last | First | Middle |

| ADDRESS: | ____________________________ |
| Street |

| City | State | Zip |

| Date of Birth | Place of Birth (City & State) |
| ____________ | ____________________________ |

| Social Security Number |
| ____________ |

| Preferred Pharmacy |
| ____________________________ |

### PARENT OR GUARDIAN INFORMATION

| NAME: | ____________________________ |
| Last | First | Middle |

| ADDRESS: | ____________________________ |
| Street |

| City | State | Zip |

| Home Phone | Cell Phone |
| ____________ | ____________ |

| Social Security Number | Drivers License # |
| ____________ | ____________ |

| EMAIL ADDRESS: | ____________________________ |

### INSURANCE INFORMATION

Please provide copy of your insurance card with picture ID.

- Denti-Cal ID # ____________________________
- Healthy Kids ID # ____________________________

### EMERGENCY CONTACT

In case of emergency, whom should we call?

| Contact Name |
| ____________ |

| Relationship |
| ____________ |

| Phone |
| ____________ |

### 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.

### ETHNICITY & LANGUAGE

- Caucasian (non-Hispanic)
- Hispanic or Latino
- African American
- Asian
- American Indian/Alaskan

What is your primary language? ____________________________

### SCHOOL INFORMATION

School ____________________________ Grade____

Teacher ____________________________

### PARENT’S EMPLOYMENT

- Employer: ____________________________
- Agricultural Worker
- Unemployed

### 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’S NAME ____________________________________________________________

Last  First  Initial  Date of Birth

MEDICAL HISTORY

CIRCLE THE APPROPRIATE ANSWER

Is your child in good health?  YES  NO
Is your child under care of physician?  YES  NO
  If yes, since when? ___________________  Why? ___________________
Name of physician ____________________________________________________
Is your child taking any medication?  YES  NO
  When? ___________________  Why? ___________________
Has your child had any serious illness?  YES  NO
  When? ___________________  What? ___________________
Is your child allergic to penicillin, antibiotics or other drugs?  YES  NO
Does your child have any other allergies?  YES  NO
Has your child had surgery?  YES  NO
Is surgery contemplated?  YES  NO
Is your child subject to profuse bleeding?  YES  NO
Is your child subject to nervous disorders?  YES  NO
  Fainting?  YES  NO
  Dizziness?  YES  NO
Has your child had Hepatitis A, B or C?  YES  NO
Has your child ever had a blood transfusion?  YES  NO
Has your child been tested for tuberculosis?  YES  NO
Has your child tested positive for HIV?  YES  NO
Has your child had history of: (circle appropriate responses) diabetes, heart murmurs, asthma, kidney infection, rheumatic fever, ear infection  YES  NO

I CERTIFY THAT THE INFORMATION PROVIDED ON THESE FORMS IS COMPLETE AND ACCURATE.

___________________________________________  _______________________
PARENT’S/GUARDIAN’S SIGNATURE  DATE

____________________________  _______________________
DENTIST’S SIGNATURE  DATE

Please sign below ONLY if you would authorize your 12-18 year old child to be treated without a parent/guardian present:

CONSENT
I authorize my child __________________________ to be treated without me present at their appointment. My cell phone number is __________________________

_________________________________________  _______________________
Parent’s/Guardian’s Signature  Date

MEDICAL HISTORY INFORMATION
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