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.
- 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 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

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)

_________________________ ☐ Male ☐ Female
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
☐ Native Hawaiian
☐ Pacific Islander
☐ Multi Racial _______
☐ Other

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 murmur, 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

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