OFFICE USE:

CHART NUMBER________________________ STAFF INITIALS__________________________ TODAY'S DATE________________

Welcome to Dientes at Commercial Way

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-Cal or Denti-Cal
- 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 income tax return, pay stub, unemployment check, disability determination, or social security check. Proof of income is required every January and July.
- 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, some extractions, some root canals, and emergency treatment. We do not provide: orthodontics, gum surgery, complex extractions, posterior root canals, or cosmetic dentistry. For these procedures we will refer you to specialists.

Mid-Level Providers:

At Dientes, we utilize mid-level providers such as RDA-EF and Hygienists who are trained and licensed appropriately. As a Dientes patient, you need to be aware that some parts of your treatment may be performed by mid-level providers.

Terms of Payment:

Payments or co-payments are expected at the time of service. Fee schedules are subject to change every year.

Our Appointment Policy:

- We see patients by appointment. We expect you to arrive on time or 10 minutes before your appointment time.
- **It is the responsibility of the patient to confirm their appointment no later than 12:30pm the day before the scheduled appointment. For Monday appointments, you must confirm or reschedule no later than 12:30pm on Saturday.**
- 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 loss of your scheduled visit. If you miss two scheduled appointments (you fail to come OR cancel your appointment without giving 24-hour notice) within a 1-year period, you will be placed on a year 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.

After Hours:

For dental emergencies after-hours, please visit the nearest urgent care or emergency room.

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.

If patient is under 18 years of age, parent or legal guardian need to sign forms.

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

____ ____________________

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** **Male** **Female**

Address: ____

____ ________________________________

City **State** **Zip** **Email address**

________________ ____________________ **Permission to leave a detailed message** ☐ ☐

Home Phone **Cell Phone** **Yes** **No**

____________________ ______________________ ________________________

Date of birth **Social Security** **Preferred Language**

Preferred Pharmacy & location: ____

Emergency Information

In case of an emergency, whom should we call?

____________________________ ____________________ ____________________

Contact Name **Contact Phone** **Relationship**

Insurance Information

Please provide a copy of your insurance card and picture ID. Full payment is expected at the time of service.

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 questions. Please ask if you have questions.

Employment

Employer: ____________________

☐ Unemployed ☐ Retired ☐ Disabled ☐ Student ☐ Agricultural Worker

Housing Status

- ☐ Renting Alone
- ☐ Renting w/ others
- ☐ Own home
- ☐ Renting motel room
- ☐ Staying in shelter
- ☐ Skilled nursing facility
- ☐ Staying w/ friends/family 6 mo. or less
- ☐ Participating in transitional housing
- ☐ Staying in car, camping or street

Race

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

Veteran

- ☐ Yes
- ☐ No
- ☐ Decline to specify

Ethnicity

- ☐ Hispanic
- ☐ Decline to specify
- ☐ Non-Hispanic

Sexual Orientation

- ☐ Lesbian or gay
- ☐ Straight (not lesbian or gay)
- ☐ Bisexual
- ☐ Something else
- ☐ Don't know
- ☐ Choose not to disclose

Gender Identity

- ☐ Choose not to disclose
- ☐ Male
- ☐ Female
- ☐ Transgender Female/Male-Female
- ☐ Transgender Male/Female-to-Male

dientes COMMUNITY DENTAL

DIENTES CONFIDENTIAL HEALTH HISTORY

Patient Name: ____________________________________Date of Birth: _________________________

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

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.)**

- ☐ ADD/ADHD
- ☐ AIDS/HIV
- ☐ Allergies, seasonal
- ☐ Allergies, other____________
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asperger's
- ☐ Assisted living
- ☐ Asthma
- ☐ Autism/ on spectrum
- ☐ Autoimmune disease
- ☐ Back/ neck issue
- ☐ Balance/ coordination
- ☐ Bell's Palsy
- ☐ Bipolar
- ☐ Bleeding problems
- ☐ Blind/ near blind
- ☐ Bone marrow transplant
- ☐ Brain injury (traumatic)
- ☐ Bruise easily
- ☐ Bruxism/ clenching
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chemotherapy
- ☐ Chest pain/angina
- ☐ Chromosome disorder
- ☐ Cognitive difficulties
- ☐ COPD/ breathing issues
- ☐ Deaf/ hearing loss
- ☐ Depression
- ☐ Developmental disorder
- ☐ Developmental delay
- ☐ Diabetes
- ☐ Dialysis
- ☐ Difficulty swallowing
- ☐ Digestive issues
- ☐ Dry mouth
- ☐ Eating disorder
- ☐ Embolism/ aneurysm
- ☐ Endocrine disorder
- ☐ GERD/ acid reflux
- ☐ Heart attack, Date____
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Heart surgery
- ☐ Heart valve replaced
- ☐ Hepatitis A, B, or C
- ☐ Herpes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Joint replacement
- ☐ Lupus
- ☐ Lyme diseases
- ☐ Lymphoma
- ☐ Liver disease
- ☐ Memory problems
- ☐ Metabolic disorder
- ☐ Migraines
- ☐ Mental impairment
- ☐ Multiple sclerosis
- ☐ Organ transplant
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Peripheral neuropathy
- ☐ Physical disability
- ☐ Prior addiction:
- ☐ Alcohol______other______
- ☐ Psychiatric care
- ☐ PTSD
- ☐ Radiation,
- ☐ Area_______ Date_______
- ☐ Rheumatic fever
- ☐ Regional pain syndrome
- ☐ Schizophrenia
- ☐ Seizures
- ☐ Sensory disorder
- ☐ Skin condition
- ☐ Sleep apnea
- ☐ Steroid use
- ☐ Stomach problems
- ☐ Stoke, Date______
- ☐ Surgery:
- ☐ What___________ Date_______
- ☐ Therapy (physical, etc.)
- ☐ Thyroid disease
- ☐ TMJ/ TMD
- ☐ Tonsils removed
- ☐ Trigeminal neuralgia
- ☐ Tuberculosis
- ☐ Tumors (non-cancer)
- ☐ Ulcer
- ☐ Vertigo/ dizziness
- ☐ Wheelchair:
- ☐ Can transfer
- ☐ Cannot transfer
- ☐ Other __________________

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

dientes COMMUNITY DENTAL

DIENTES CONFIDENTIAL HEALTH HISTORY

III. **ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?**

- ☐ Aspirin
- ☐ Local anesthetic
- ☐ Nitrous oxide
- ☐ Antibiotics
- ☐ Metals
- ☐ Penicillin
- ☐ Food
- ☐ Pain Medication
- ☐ Sedatives
- ☐ Latex
- ☐ Acrylic
- ☐ ***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?**

- ☐ Alcohol
- ☐ Antibiotics
- ☐ Aspirin
- ☐ Bisphosphonates
- ☐ Blood Thinners
- ☐ Digitalis
- ☐ Nitroglycerin
- ☐ Recreational drugs
- ☐ Supplements
- ☐ Tabaco in any form
- ☐ Weight loss meds
- ☐ ***NONE***

Have you ever taken Fen-phen? 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 you understand that antibiotics (and other medications) may have 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 and 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.)

____

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 Signature: ____ Date: ____________________

Physician's Name: ____ Date: ____________________

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 of Guardian) Date Signature of Dentist Date

DIENTES CONFIDENTIAL HEALTH HISTORY

III. **ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?**

☐ Aspirin ☐ Metals ☐ Sedatives
☐ Local anesthetic ☐ Penicillin ☐ Latex
☐ Nitrous oxide ☐ Food ☐ Acrylic
☐ Antibiotics ☐ Pain Medication ☐ ***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?**

☐ Alcohol ☐ Blood Thinners ☐ Supplements
☐ Antibiotics ☐ Digitalis ☐ Tabaco in any form
☐ Aspirin ☐ Nitroglycerin ☐ Weight loss meds
☐ Bisphosphonates ☐ Recreational drugs ☐ ***NONE***

Have you ever taken Fen-phen? 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

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____

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____
Signature of Patient (Parent of Guardian) Date Signature of Dentist Date

dientes
COMMUNITY DENTAL

PLEASE READ & SIGN BELOW

Acknowledgement of Receipt of Notice of Privacy Practices

I, ____ have been given an opportunity to read and review this office's Notice of Privacy Practices.

______________________________ ________________
Signature Date

Patient Acknowledgement For Receipt of Dental Materials Fact Sheet

I, ____ have been given an opportunity to read and review the Dental Materials Fact Sheet dated May 2004 from Dientes Community Dental Care.

______________________________ ________________
Signature Date

Photo Release:

I hereby authorize and give full consent to Dientes Community Dental Care 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

CONSENT FOR TREATMENT

____

Patient Name   Date of Birth

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I understand that each Dentist is an individual practitioner and is responsible for the dental care rendered to me. I hereby authorize any of the doctors or dental auxiliaries of Dientes Community Dental Care to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or un-diagnosable circumstances that may arise during treatment.

Should any dispute arise over dental service provided to me, that is whether any dental service rendered as allegedly unnecessary, unauthorized or was improperly, negligently, or incompetently performed, said dispute will be submitted to the Quality Committee. The decision of the Quality Committee shall be binding on both parties. I have read, understood, and agree to the above. I agree that a photocopy of this authorization shall be valid and effective as the original forever. I am of legal age and legally competent to make this assignment.

Permission Granted for Review of Medical Records.

Signature: ____**Date:**______________________