

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



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.)

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

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



DIENTES CONFIDENTIAL HEALTH HISTORY

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

- | | | |
|---|--|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Metals | <input type="checkbox"/> Sedatives |
| <input type="checkbox"/> Local anesthetic | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Nitrous oxide | <input type="checkbox"/> Food | <input type="checkbox"/> Acrylic |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Pain Medication | <input type="checkbox"/> 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?

- | | | |
|--|---|--|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Supplements |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Digitalis | <input type="checkbox"/> Tobacco in any form |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Nitroglycerin | <input type="checkbox"/> Weight loss meds |
| <input type="checkbox"/> Bisphosphonates | <input type="checkbox"/> Recreational drugs | <input type="checkbox"/> 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.



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 undiagnosable 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:** _____