**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.

<table>
<thead>
<tr>
<th>Patient Information</th>
<th>Parent or Guardian Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: ___________________________</td>
<td>Name: __________________________</td>
</tr>
<tr>
<td>Last                                         First           M</td>
<td></td>
</tr>
<tr>
<td>Address: ______________________________________</td>
<td>Address: __________________________________________</td>
</tr>
<tr>
<td>City                                         State          Zip</td>
<td></td>
</tr>
<tr>
<td>Date of birth</td>
<td>Social Security Number</td>
</tr>
<tr>
<td>☐ Male</td>
<td>☐ Female</td>
</tr>
</tbody>
</table>

Preferred Pharmacy

Emergency Information
In case of an emergency, whom should we call?

<table>
<thead>
<tr>
<th>Contact Name</th>
<th>Contact Phone</th>
<th>Relationship</th>
</tr>
</thead>
</table>

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.

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

Veteran
☐ Yes
☐ No
☐ Decline to specify

Ethnicity
☐ Hispanic
☐ Non-Hispanic
☐ Decline to specify

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

Sexual Orientation
☐ Lesbian or gay
☐ Straight (not lesbian or gay)
☐ Bisexual
☐ Something else
☐ Don’t know
☐ Choose not to disclose
Child Medical History

Please check all conditions that apply:

- ADD/ADHA
- Allergies, seasonal
- Allergies, other ______
- Anemia
- Anxiety
- Asperger’s
- Asthma
- Autism/on spectrum
- Bleeding problems
- Bipolar
- Cancer
- Cerebral palsy
- Chromosome difficulties
- Cognitive difficulties
- Depression
- Developmental delay
- Diabetes/ Pre-diabetes
- Eating disorder
- Endocrine disorder

- Genetic conditions
- Heart conditions
- Heart murmur
- Hepatitis A, B, C
- HIV
- Metabolic Disorder
- Migraines/ Headaches
- Physical Disability
- PTSD
- Rheumatic Fever
- Schizophrenia
- Seizures
- Sensory Disorder
- Sleep Apnea
- Therapy (Physical, Etc.)
- Tonsils Removed
- Tuberculosis
- Tumors (Non-cancer)

WHEELCHAIR:  
CAN TRANSFER ☐  CAN NOT TRANSFER ☐  N/A ☐

SURGERY:  Yes ☐  No ☐

Date & Reason: ____________________________________________________________________________________________

I certify that the information provided on these forms are complete and accurate.

________________________________________________________   ___________________________
Parent/Guardian Signature        Date

________________________________________________________   ___________________________
Dentist Signature         Date

Please sign below ONLY if you authorize your child to be treated without a parent or guardian present.

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

_________________________________________________________   ___________________________
Parent or Guardian Signature         Date
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

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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

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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
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: ___________________