

OFFICE USE:

CHART NUMBER \_\_\_\_\_ STAFF INITIALS \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_



**dientes**  
COMMUNITY DENTAL CARE

## WELCOME TO DIENTES IN WATSONVILLE

### Who We Are and Our Mission:

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 is 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 by the Watsonville Health Center who qualify under their ATP discount program.
- Watsonville residents only

### 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 you will be referred to specialists.

At Dientes, we utilize mid-level providers such as RDA-EFs and Hygienists who are trained and licensed appropriately. As a Dientes patient, please be aware that some portions of your treatment may be performed by these mid-level providers.

### Location Transfers:

At this time there is no availability to transfer to another Dientes location. If there is a service a certain location is unable to provide, we will refer you to another location **for that appointment only.**

### Terms of Payment:

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

### After Hours:

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

### Appointment Policies:

- Patients are seen by appointment. **We expect you to arrive on time or 10 minutes before your scheduled appointment time. *It is the responsibility of the patient*** to confirm or reschedule 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 Friday. We will attempt to give you a courtesy call to confirm. You may confirm your appointment with us 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 one-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.

### 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.**

***A signature below indicates I have read and understand the above information regarding Clinic Policies at Dientes in Watsonville***

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

***If patient is under 18 years of age, parent or legal guardian must sign forms***

# PATIENT INFORMATION & DEMOGRAPHICS

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**.

Name: \_\_\_\_\_  
Last First Middle

Preferred Name: \_\_\_\_\_

Pronouns Used (circle): she/her/hers he/him/his they/them/theirs Other: \_\_\_\_\_

Date of Birth: \_\_\_\_\_(MM/DD/YY) Social Security Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

\_\_\_\_\_  
City State Zip Email address

\_\_\_\_\_  
Home Phone Cell Phone Permission to leave a detailed message?  Yes  No

Preferred Language: \_\_\_\_\_ Preferred Pharmacy: \_\_\_\_\_

## Emergency Information

In case of an emergency, whom should we call?

\_\_\_\_\_  
Contact Name Contact Phone Relationship

The following information is *optional*. Dientes Community Dental Care is a non-profit organization. We are asked to report patient demographics for grants, which enable us to continue to provide low-cost, quality dental care. We appreciate your willingness to answer the following questions. Please ask if you have any questions

## Employment

Employer: \_\_\_\_\_  
 Unemployed  Retired  Disabled  Student  Agricultural Worker

## Housing Status

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

## Race

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

## Veteran

Yes  
 No  
 Decline to specify

## Ethnicity

Hispanic  
 Non-Hispanic  
 Decline to specify

## Sexual Orientation

Lesbian or gay  
 Straight (not lesbian or gay)  
 Bisexual  
 Other  
 Don't know  
 Decline to specify

## Gender Identity

Male  
 Female  
 Nonbinary  
 Transgender Female/Male-Female  
 Transgender Male/Female-Male  
 Other/Don't know  
 Decline to specify

# CONFIDENTIAL PATIENT HEALTH HISTORY

Please fill out this form *completely*. The better communication we have, the better we can care for *YOU*.

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Are you under a physician's care now?  Yes  No If yes, please explain:  
\_\_\_\_\_

Have you even been hospitalized or had a major operation/surgery?  Yes  No If yes, please explain:  
\_\_\_\_\_

Have you ever had a serious head or neck injury?  Yes  No If yes, please explain:  
\_\_\_\_\_

<b>MEDICATIONS- List ALL medications, pills, or drugs you are currently taking:</b>			
<b>Women:</b> Mark all that apply	<input type="checkbox"/> Pregnant	<input type="checkbox"/> Nursing	<input type="checkbox"/> Taking oral contraceptives
<i>It is important you understand that antibiotics and other medications may interfere with the effectiveness of oral contraceptives. After consultation with your physician, alternatives to oral contraceptives may be needed when taking antibiotics</i>			

<b>Are you CURRENTLY taking, or have you ever taken any of the following?</b>		
<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 Medication
<input type="checkbox"/> Bisphosphonates	<input type="checkbox"/> Recreational Drugs	<input type="checkbox"/> NONE

<b>ALLERGIES- Are you allergic to any of the following?</b>		
<input type="checkbox"/> Codeine	<input type="checkbox"/> Metal, please specify:	<input type="checkbox"/> Other Antibiotics
<input type="checkbox"/> Latex	<input type="checkbox"/> Pain Medication	<input type="checkbox"/> No Known Drug Allergies
<input type="checkbox"/> Local Anesthetic	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Other, please specify:

<b>HEALTH HISTORY- Do you currently have, or have you ever had, any of the following conditions? Check all that apply.</b>			
<b>Cardiovascular</b>		<b>Developmental/Mental &amp; Behavioral Health</b>	
<input type="checkbox"/> Chest Pain/Angina	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Developmental Delay or Disorder
<input type="checkbox"/> Embolism/Aneurysm	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Addiction: Past or Current. Alcohol, Other	<input type="checkbox"/> Eating Disorder
<input type="checkbox"/> Heart Attack, Date:	<input type="checkbox"/> Irregular heart rhythm	<input type="checkbox"/> Autism Spectrum Disorder	<input type="checkbox"/> Memory Problems
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Bipolar	<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Stroke, Date:	<input type="checkbox"/> Cognitive Difficulties	<input type="checkbox"/> PTSD
<input type="checkbox"/> Heart Valve Replacement	<input type="checkbox"/> Other	<input type="checkbox"/> Depression	<input type="checkbox"/> Schizophrenia
<b>Endocrine</b>		<b>Immunologic/Allergic</b>	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Steroid Use	<input type="checkbox"/> Allergies	<input type="checkbox"/> Autoimmune Disease
<input type="checkbox"/> Endocrine Disorder	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Sjogrens

<b>Respiratory</b> <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> COPD <input type="checkbox"/> Emphysema <input type="checkbox"/> Tuberculosis, treated or active? <input type="checkbox"/> Other		<b>Gastrointestinal/Gastrourinary</b> <input type="checkbox"/> GERD/Acid Reflux <input type="checkbox"/> Dialysis <input type="checkbox"/> Hepatitis A, B, C <input type="checkbox"/> Liver or Kidney Disease <input type="checkbox"/> Stomach Problems <input type="checkbox"/> Stomach Ulcers	
<b>Hematologic/Lymphatic</b> <input type="checkbox"/> AIDS/HIV <input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding Problems <input type="checkbox"/> Bruise Easily <input type="checkbox"/> Cancer, Date: Chemo, Date: Radiation, Date: <input type="checkbox"/> Herpes <input type="checkbox"/> Organ Transplant		<b>Ear/Nose/Throat</b> <input type="checkbox"/> Blind/Near Blind <input type="checkbox"/> Bruxism/Clenching <input type="checkbox"/> Deaf/Hearing Loss <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Dry Mouth <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> TMD/TMJ	
<b>Musculoskeletal</b> <input type="checkbox"/> Arthritis <input type="checkbox"/> Back/Neck Issues <input type="checkbox"/> Joint Replacement, Date: <input type="checkbox"/> Physical Disability <input type="checkbox"/> Therapy (physical, etc.) <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Wheelchair, can transfer? Y/N		<b>Neurological</b> <input type="checkbox"/> Balance/Coordination Difficulties or Vertigo <input type="checkbox"/> Bell's Palsy <input type="checkbox"/> Migraines <input type="checkbox"/> Peripheral Neuropathy <input type="checkbox"/> Sensory Disorder <input type="checkbox"/> Seizures <input type="checkbox"/> Trigeminal Neuralgia	
<b>Is there any condition or issue that you have that is NOT listed above?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>If yes, please explain:</b>			

**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 if needed.*

Physician's Name & Contact Information: \_\_\_\_\_

*A signature below indicates I certify that I have read and understand this form. To the best of my knowledge, I have answered the questions on this form completely and accurately. I am responsible for informing my dentist of any change in my health and/or medication(s). Further, I will not hold my dentist or any other member of his/her staff responsible for any error or omissions I may have made in the completion of this form.*

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

*If patient is under 18 years of age, parent or legal guardian must sign forms*

\_\_\_\_\_  
**Dentist Signature**

\_\_\_\_\_  
**Date**

## Patient 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.

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Signature

Date

*If patient is under 18 years of age, parent or legal guardian must sign forms*

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## Patient Acknowledgement For Receipt of Dental Materials Fact Sheet

I have been given the opportunity to read and review Dientes' Dental Materials Fact Sheet dated May 2004.

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Signature

Date

*If patient is under 18 years of age, parent or legal guardian must sign forms*

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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

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Signature

Date

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# **GENERAL CONSENT FORM**

I understand that dentistry is not an exact science and therefore reputable practitioners cannot properly guarantee results. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

I understand 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 this is only an estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during treatment.

My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment I am unsure about.

Most dental procedures require the use of dental anesthetic or numbing to complete the procedure. I understand there are risks involved in using anesthetic which include permanent or temporary loss of feeling and/or muscle control from nerve damage, pain from injection site including muscle tightness or even muscle damage that may or may not go back to normal, allergic reaction, and other side effects.

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 Dientes' Quality and Risk Management Committee. The decision of the Quality Committee shall be binding on both parties.

*A signature below indicates I have read, understood, and agree to the above. I also agree that a photocopy of this authorization shall be valid and effective as the original forever. I am of legal age and legal competency to make this assignment. I also grant permission for review of medical records.*

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**Signature**

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**Date**

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