OFFICE USE:
CHART NUMBER_____ **STAFF INITIALS**_____ **TODAY'S DATE**_____

dientes
COMMUNITY DENTAL CARE

WELCOME TO DIENTES ON CAPITOLA ROAD

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 from special programs, such as the Homeless Persons Health Project, E.I.S, etc.
- Persons with low income. We define low income as people 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 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:
- **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.**

By signing below, you are agreeing and fully understand the above information regarding Clinic Policies at Dientes on Capitola Road.

_____ _____

Patient Signature **Today's 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 *YOUR CHILD*.

Patient Information

Name: _____ _____ _____
First Middle Last

Preferred Name: _____

Pronouns Used (circle):

she/her/hers he/him/his they/them/theirs
Other:_____

Date of Birth: _____(MM/DD/YY)

_____ _____
Home Phone **Cell Phone**

Preferred Language: _____

Parent or Guardian Information

Name: _____ _____ _____
First Middle Last

Mailing Address: _____

_____
City State Zip

Email Address:_____

Social Security Number:_____

Permission to leave a detailed message? ☐ **Yes** ☐ **No**

Preferred Pharmacy: _____

Emergency Information

In case of an emergency, whom should we call?

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

Is your child a patient at Santa Cruz Community Health Center? ☐ **YES** ☐ **NO**

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
☐ 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-Racial

Veteran

☐ Other
☐ Decline to specify
☐ Yes
☐ No

Ethnicity

☐ Decline to specify
☐ 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 PEDIATRIC PATIENT HEALTH HISTORY

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

Patient Name:_____ **Date of Birth:**_____

MEDICATIONS- List ALL medications, pills, or drugs the patient is currently taking:

ALLERGIES- Is the patient allergic to any of the following?

- ☐ **Codeine**
- ☐ **Latex**
- ☐ **Local Anesthetic**
- ☐ **Metal, please specify:**
- ☐ **Pain Medication**
- ☐ **Penicillin**
- ☐ **Other Antibiotics**
- ☐ **No Known Drug Allergies**
- ☐ **Other, please specify:**

HEALTH HISTORY- Does the patient currently have, or ever had, any of the following conditions? Check all that apply.

Cardiovascular

- ☐ Heart Conditions, specify
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Irregular Heart Rhythm
- ☐ Other, specify

Ear/Nose/Throat

- ☐ Blind/Near Blind
- ☐ Bruxism/Clenching
- ☐ Deaf/Hearing Loss
- ☐ Sleep Apnea
- ☐ Tonsils Removed

Respiratory

- ☐ Asthma
- ☐ Tuberculosis, treated or active?
- ☐ Other, specify

Immunologic/Allergic

- ☐ Allergies
- ☐ Anaphylaxis
- ☐ Autoimmune Disease

Endocrine

- ☐ Diabetes/Pre-Diabetes
- ☐ Endocrine Disorder
- ☐ Thyroid Disease

Gastrointestinal/Gastrourinary

- ☐ Dialysis
- ☐ Hepatitis A, B, C
- ☐ Liver or Kidney Disease
- ☐ Stomach Problems

Musculoskeletal

- ☐ Back/Neck Issues
- ☐ Physical Disability
- ☐ Therapy (physical, etc.)
- ☐ Wheelchair, Can Transfer? Y/N

Neurological

- ☐ Balance/Coordination Difficulties or Vertigo
- ☐ Migraines/Headaches
- ☐ Sensory Disorder
- ☐ Seizures

Developmental/Mental & Behavioral Health

- ☐ ADD/ADHD
- ☐ Anxiety
- ☐ Autism Spectrum Disorder
- ☐ Bipolar
- ☐ Cerebral Palsy
- ☐ Chromosome Disorder
- ☐ Cognitive Difficulties
- ☐ Depression
- ☐ Developmental Delay or Disorder
- ☐ Eating Disorder
- ☐ Genetic Conditions
- ☐ Premature Birth
- ☐ PTSD
- ☐ Schizophrenia

Hematologic/Lymphatic

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Bleeding Problems
- ☐ Cancer, Date: Chemo, Date: Radiation, Date:
- ☐ Organ Transplant
- ☐ Tumors, non-cancerous

Is there any condition or issue that the patient has that is NOT listed above?	☐ **Yes**	☐ **No**
If yes, please explain:		

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.

_____ _____

Signature **Date**

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

_____ _____

Dentist Signature **Date**

AUTHORIZATION FOR PEDIATRIC TREATMENT WITHOUT PARENT or GUARDIAN PRESENT

You may authorize your child to be treated at Dientes Community Dental Care without a parent or guardian present at their appointment. This authorization will remain in effect until you notify us in writing, unless you specify a date below.

Patient Name: _____ **Date of Birth:** _____(MM/DD/YY)

Date of Request:_____(MM/DD/YY) **End Date of Request:**_____(MM/DD/YY)

(if these dates are left blank this will remain in effect until we receive written notice to stop)

I authorize my child to be treated without a parent or guardian present at their appointment. A parent or guardian contact number is _____.

A signature below indicates I understand and acknowledge it is my responsibility to inform Dientes of any changes.

_____ _____

Signature **Date**

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

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.

_____ _____

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.

_____ _____

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***

_____ _____

Signature **Date**

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

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Patient Acknowledgment For Receipt of the Good Faith Estimate

I have been given the opportunity to read and review the Good Faith Estimate form

_____ _____

Signature **Date**

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

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.

_____ _____

Signature **Date**

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