

# 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

ADDRESS: \_\_\_\_\_  
Street

City State Zip

Home Phone Work Phone Message

Date of Birth Place of Birth (City & State)

Male  Female

Social Security Number

## **FULL PAYMENT IS EXPECTED AT THE TIME OF EACH APPOINTMENT.**

How will you be paying today?

Cash \_\_\_\_\_ Check \_\_\_\_\_ Credit Card \_\_\_\_\_

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 following questions. Please ask the receptionist if you have questions.

## EMPLOYMENT

Employer: \_\_\_\_\_

Unemployed  Veteran  Agricultural Worker

## ETHNICITY & LANGUAGE

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

## INSURANCE INFORMATION

Denti-Cal ID # \_\_\_\_\_

Healthy Families ID # \_\_\_\_\_

EIP  Homeless Project

Other \_\_\_\_\_

## EMERGENCY INFORMATION

In case of emergency, whom should we call?

\_\_\_\_\_ Contact Name

\_\_\_\_\_ Relationship

\_\_\_\_\_ Phone

What is your primary language? \_\_\_\_\_

## HOUSING STATUS

Renting alone  
 Renting with others  
 Own home  
 Staying with friends or family less than 6 months  
 Renting a motel room  
 Staying in a shelter  
 Participating in transitional housing program  
 Staying in your Car, Camping, or on the Street

## PATIENT REGISTRATION INFORMATION

PATIENT'S NAME \_\_\_\_\_  
 Last First Initial SSN# Date of Birth

**DENTAL HISTORY**

**Present Dental History:**

1. Name of your dentist \_\_\_\_\_
2. When was your last visit to the dentist? \_\_\_\_\_
3. What is the purpose of this visit to the dentist? \_\_\_\_\_
4. Is there any area in your mouth sore to pressure or irritants?..... Yes No  
 Cold, hot, sweets, other \_\_\_\_\_
5. Do you chew on one side of your mouth?..... Yes No
6. Are you aware of a bad taste or odor in your mouth?..... Yes No
7. Do your gums bleed? ..... Yes No  
 If so, when? \_\_\_\_\_
8. Does your jaw ever click or cause pain upon opening or closing?..... Yes No
9. Have you noticed a shift in your teeth or bite?..... Yes No
10. Do you clench or grind your teeth?..... Yes No

**Past Dental History**

1. Have you had any problems from prior dental treatment?..... Yes No
2. Have you ever had any complications from extractions or dental procedures?..... Yes No
3. Have you ever had any lumps or swelling in the mouth?..... Yes No
4. Have you ever had oral/facial injury?..... Yes No
5. Do you have a history of cavities, toothaches, pain, broken teeth or extra permanent teeth?..... Yes No
6. Did your mother and father have a lot of tooth decay?..... Yes No
7. Have you been instructed in the care of your teeth?..... Yes No
8. Have you ever had an acute sore mouth, gum boils or fever blisters/cold sores on the lips or mouth?..... Yes No
9. Have you taken fluoride (drops, tablets, vitamins)?..... Yes No
10. Do you have any mouth habits (nail biting, etc.)?..... Yes No
11. Do you have any other dental or oral disease or condition not listed?..... Yes No

**DENTAL HISTORY INFORMATION**

# CONFIDENTIAL HEALTH HISTORY

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

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

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

- |   |     |    |  |
|---|-----|----|--|
| 1 | Yes | No | Is your general health good?<br>If NO, explain _____   |
| 2 | Yes | No | Has there been a change in your health within the last year?<br>If YES, explain _____  |
| 3 | Yes | No | Have you gone to the hospital or emergency room or had a serious illness in the last three (3) years?<br>If YES, explain _____                     |
| 4 | Yes | No | Are you being treated by a physician now? If YES, explain _____<br>Date of last medical exam? _____ Reason for exam _____                          |
| 5 | Yes | No | Have you had problems with prior dental treatment?<br>If YES, explain _____<br>Date of last dental exam? _____ Name of last treating dentist _____ |
| 6 | Yes | No | Are you in pain now?<br>If YES, explain _____  |

**II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Please Circle)**

- |   |   |   |   |
|---|---|---|---|
| Reviewed<br><br>YES<br><input type="checkbox"/><br><br>NO<br><input type="checkbox"/> | Chest pain (Angina)<br>Fainting spells<br>Recent significant weight loss<br>Fever<br>Night Sweats<br>Persistent cough<br>Coughing up blood<br>Bleeding problems<br>Blood in urine | Blood in stools<br>Jaundice<br>Frequent urination<br>Difficulty urinating<br>Ringing in ears<br>Headaches<br>Dizziness<br>Blurred vision<br>Bruise easily | Frequent vomiting<br>Difficulty swallowing<br>Dry mouth<br>Excessive thirst<br>Swollen ankles<br>Joint pain or stiffness<br>Shortness of breath<br>Sinus problems |
|---|---|---|---|

**III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please Circle)**

- |   |  |   |   |
|---|--|---|---|
| Reviewed<br><br>YES<br><input type="checkbox"/><br><br>NO<br><input type="checkbox"/> | Heart disease<br>Family history of heart disease<br>Heart attack<br>Artificial joint<br>Stomach problems or ulcers<br>Heart defects<br>Heart murmurs<br>Rheumatic fever<br>Skin disease<br>Hardening of arteries<br>High blood pressure<br>Seizures<br>Cosmetic surgery<br>Are you active now? _____ | AIDS/HIV<br>Surgeries<br>Hospitalization<br>Diabetes<br>Family history of diabetes<br>Tumors or cancer<br>Chemotherapy<br>Radiations<br>Arthritis, rheumatism<br>Emphysema or other lung disease<br>Kidney or bladder disease<br>Stroke<br>Eating disorders<br>Are you being treated? _____ | Psychiatric care<br>Osteoporosis<br>Thyroid disease<br>Asthma<br>Hepatitis<br>Sexually transmitted disease<br>Herpes<br>Canker or cold sores<br>Anemia<br>Liver disease<br>Eye disease<br>Organ transplant<br>Were you treated in the past? _____ |
|---|--|---|---|

**IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please Circle)**

- |   |   |  |  |
|---|---|--|--|
| Reviewed<br><br>YES<br><input type="checkbox"/><br><br>NO<br><input type="checkbox"/> | Aspirin<br>Darvon<br>Codeine<br>Local anesthetic(Novacaine/Lidocaine)<br>Nitrous oxide<br>Other _____ | Valium<br>Demerol<br>Penicillin<br>Latex<br>Erythromycin | Tetracycline<br>Vicodin<br>Percodan<br>Food<br>Metal |
|---|---|--|--|

**V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (Please Circle)**

- |   |   |  |  |
|---|---|--|--|
| Reviewed<br><br>YES<br><input type="checkbox"/><br><br>NO<br><input type="checkbox"/> | Recreational drugs<br>Over-the-counter medications<br>Weight loss medications<br>Blood thinners<br>Please list: _____ | Tobacco in any form<br>Alcohol<br>Bisphosphonates (Fosamax)<br>Digitalis | Antibiotics<br>Supplements<br>Aspirin<br>Nitroglycerin |
|---|---|--|--|



## *Welcome to Dientes*

*We hope your visit with us is a pleasant experience.*

*Here's how our clinic works*

**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/Denti-Cal, Healthy Families or Healthy Kids.
- Persons referred from special programs, such as the Homeless Persons Health Project, E.I.P, 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 an income tax return, pay stub, unemployment check, disability determination, or social security check.
- Persons without private insurance.

**What we do:** We provide basic dental services such as: examinations, x-rays, cleanings, sealants, fillings, crowns, dentures, extractions, some root canals, and emergency treatment. We do not provide: orthodontics, gum surgery, complex extractions or root canals, cosmetic dentistry. For these procedures we will refer you to specialists.

**Terms of payment:** Our policy is payment at the time of service. If we bill insurance and you have a co-pay which was not collected, we will invoice you for the remaining balance.

**Our appointment policies:** We see patients by appointment, like any other private office.

- We expect you to arrive on time or 10 minutes before.
- **It is the responsibility of the patient to confirm their appointment 48 hours prior to the appointment time.** 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 may result in the loss of your scheduled visit.**
- **If you miss two scheduled appointments (you fail to come OR cancel your appointment without giving proper notice) within a six-month period, you will be placed on a 6 month probation. If another appointment is missed while being 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. If you have any concerns about your dental treatment, you may submit your concern in writing and it will be addressed. The front office staff will supply you with a form. We also have a patient satisfaction survey available for your feedback.**

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

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date