Community Dental Center
We Care for Kids

FORMERLY KNOWN AS THE COMMUNITY CHILDREN'S DENTAL CENTER

Welcome to the Community Dental Center!

We are pleased to have you be a part of our family. We are committed to providing quality dental care for children that have Medicaid or that are uninsured. Our goal is to make a lasting difference in a child's dental health and overall development. This is why with every visit children receive nutritional counseling and oral hygiene instruction and taught to take personal responsibility for their dental health.

We care about each and every patient that we serve. In order to do so, please give us 24 hours' notice of changes or cancellations of appointments. We are a non-profit dental clinic and cannot produce enough money to keep our doors open if you do not keep your appointment or/and cancel at the last minute. Help us continue to provide dental services in your area!

Please remember that minors (under the age of 18) must have an adult present at all times during appointment, either in the waiting room or exam room. Guardians may not drop the child off and leave the building. The child will not be treated if no adult is present.

BE A PART OF THE SOLUTION

Share your knowledge of Community Dental Center!

Thank you for doing your best and we will do our best for you!

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PATIENT INFORMATION AND HEALTH HISTORY FORM
INFORMACION DEL PACIENTE

Child's Name (nombre del joven): _____
Birthdate (Nacimiento) : _____/_____/_____ Age (edad) : _____
Sex (sexo) : ❑Male ❑Female
How did you hear about us? _____

PARENT INFORMATION
PADRES INFORMACION

Legal Guardian Name:_____Relationship:_____ Custody? _____
Phone number: _____
Address:_____
Employer:_____
Legal Guardian Name: _____Relationship: _____ Custody? _____
Phone number: _____
Address: _____
Employer (empleador): _____
If mother and father do not share custody, do we have permission to share information with both? ____
What is the parent's primary language? _____
(¿Cuál es el idioma primario del padre?)
What is the child's primary language? _____
(¿Cuál es el idioma principal del niño?)
Email:_____

EMERGENCY CONTACT
CONTACTO DE EMERGENCIA

**Please list someone other than yourself.*
Name (Nombre): _____
Relationship (relación): _____
Home Phone (Teléfono): _____
Work Phone (teléfono del trabajo) : _____
Mobile(móvil): _____

MEDICAL HISTORY
HISTORIA MEDICA

- *For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your child's initial visit you and your child will be asked some questions about your responses to this questionnaire and there may be additional questions concerning his/her health. If you have any questions, please feel free to ask.*
- *Por favor conteste las siguientes preguntas de la forma "si" o "no", marcando sus respuestas con un circulo. Su informacion es confidencial y protegida por ley. Durante su visita, el doctor solicitara mas informacion de ud, y del joven paceiente. Por Favor estese preparado a elaborar sobre sus respuestas a estas y otras preguntas relacionadas a la salud del paciente. Si usted o el joven tienen cualquier pregunta o preocupacion, por favor mencionenlas; el doctor esta mas que disponible para ofrecerle una respuesta.*

****Do you have any illness today such as a fever, flu symptoms, a cold, sore throat, or stomach pain? Please describe. _____**

General Conditions

Arthritis	Yes	No	Gastrointestinal disorders	Yes	No
Asthma	Yes	No	Heart disease	Yes	No
Diabetes	Yes	No	Heart murmur	Yes	No
Kidney disease	Yes	No	Rheumatic fever	Yes	No

Hematological (Blood-related)

Anemia	Yes	No	Bleeding (prolonged)	Yes	No
Hemophilia	Yes	No	Sickle cell trait	Yes	No
Sickle cell disease	Yes	No	Transfusion of blood	Yes	No

Behavior/Learning

ADHD	Yes	No	Anxiousness/Nervousness	Yes	No
Autism	Yes	No	Behavior issues	Yes	No
Emotional disability	Yes	No	Learning disability	Yes	No
Psychiatric disorder	Yes	No			

Infectious

Hepatitis	Yes	No	HIV infection (AIDS)	Yes	No
Tuberculosis	Yes	No	Venereal disease	Yes	No

Developmental

Brain injury	Yes	No	Cerebral palsy	Yes	No
Cleft lip/palate	Yes	No	Developmental delay	Yes	No
Growth problems	Yes	No	Feeding/eating problems	Yes	No
Hearing loss	Yes	No	Neuromuscular defect	Yes	No
Orthopedic problems	Yes	No	Seizures	Yes	No
Spina bifida	Yes	No	Other: _____		

_____

If any checked yes, please explain: _____

_____

Substance Abuse

Drug use	Yes	No	Tobacco use	Yes	No
Abuse	Yes	No	Alcohol Abuse	Yes	No

Other

Cancer	Yes	No	Type: _____		
Leukemia	Yes	No	Type: _____		
Fainting/headaches	Yes	No	Sleep apnea	Yes	No
Sleep problems	Yes	No	Snoring	Yes	No

Is your child currently taking any medications? Yes No
If yes, please list: _____
_____

Has your child had any surgery? Yes No
If yes, type(s), date(s) and age(s):_____
Has your child ever been hospitalized? Yes No
If yes, when, and where? _____

Name and phone number of family physician:_____

Has your child had any allergic reactions to:

- ☐ Medications or drugs? Yes No
- ☐ Latex? Yes No
- ☐ Local Anesthetics (Lidocaine) Yes No
- ☐ Penicillin or other antibiotics Yes No
- ☐ Codeine or other narcotics Yes No
- ☐ Foods? Yes No
  If yes, please list: _____
- ☐ Other? Yes No
  If yes, please explain: _____

Does your child have any disease, condition, or problem not listed above that you think the dentist should know about? _____
_____

Is your child wearing removable dental appliances?	Yes	No
Does your child drink well water?	Yes	No
Does your child suck their thumb?	Yes	No

Girls/Women Only

Has your child had her first monthly period?	Yes	No
Is your child pregnant?	Yes	No
Is your child nursing a baby?	Yes	No
Is your child taking/on any type of birth control?	Yes	No

DENTAL HISTORY
HISTORIA DENTALES

1. Last Dental Appointment? _____
2. Were X-Rays taken? Yes No Date of last X-Rays? _____
3. How did your child react? Great Ok Fair Poorly
4. Does your child brush his/her teeth? Yes No
5. Do you help in brushing your child's teeth? Yes No
6. Does your child use dental floss in cleaning their teeth? Yes No
7. Does your child snack frequently? Yes No
   - ☐ What do their snacks consist of? _____
9. How much soda and juice does your child usually drink per day? _____
10. Have your child's teeth or a tooth ever been injured? Yes No
    - ☐ Which teeth and how? _____
11. Does your child require a bottle or sippy cup to sleep or nap? Yes No
    - ☐ If yes, what is in the bottle or cup? _____
12. Does your child grind their teeth? Yes No
13. Has your child ever received any dental or surgical treatment to the mouth? Yes No
    - ☐ If yes, describe (i.e., sedated for dental treatment) _____
      _____

CONSENT FOR DENTAL TREATMENT
CONSENTIMIENTO PARA TRATAMIENTO DENTAL El

I authorize treatment and any holder of medical or other information about my child to release such information to Doral Dental USA or its intermediaries or carriers any information needed for this or a related FAMIS or FAMIS Plus claim. I request payment of medical insurance benefits to the Community Children's Dental Center. I understand that it is mandatory to notify the Community Children's Dental Center of any other party who may be responsible for payment of my treatment. To the best of my knowledge the above information is accurate. During my child's treatment I will report any changes in my child's health, illness, or medications. Problems arising from dental treatment are extremely rare but may include pain or infection. Not treating dental disease may have the same result. If a tooth cavity is very deep and the nerve and blood supply are affected, or if bone loss or swelling are present, the removal of the nerve or the tooth with local anesthesia, may be necessary. Please feel free to discuss any concerns you have with the dentist. I authorize the dentist to perform on my child a dental examination and treatments such as deemed necessary by the dentist. **Notice of Deemed Consent for HIV, HBV, and HCV Testing: If one of our health care professionals, workers, or employees should be directly exposed to blood or body fluids in a way that may transmit disease, your child's blood will be tested for infection with Human Immunodeficiency Virus (HIV, the AIDS Virus) and for the presence of the Hepatitis B and Hepatitis C Virus.** A physician or other health care provided will tell you and that person the result of the test and provided counseling, if necessary. **A consent to obtain test results will be signed and sent to the health care provider so we may obtain your child's test results directly.** If your child should be directly exposed to blood or body fluids of one of our health care professionals, workers or employees in a ways that may transmit disease, that person's blood will be tested for infection with Human Immunodeficiency Virus (HIV, the AIDS Virus) and for the presence of the Hepatitis B and Hepatitis C Viruses. A physician or other health care provider will tell you and that person the result of the test and provide counseling, if necessary. I will not hold my dentist, or any other member of staff of the Community Children's Dental Center, responsible for any errors or omissions that I may have had in the completion of this form. Also, by my signature below, I acknowledge that the Notice of Privacy practices is posted and I may request a copy at any time.

Signature: _____ Date: _____

(Parent/Guardian

APPOINTMENT POLICIES

Community Dental Center relies on community funding, grants and Medicaid reimbursements to continue offering services in the community. Therefore, the following policies are necessary for all patients to follow to allow for the most efficient use of our resources:

- Appointments must be confirmed within 48 hours of the appointment date/time or your appointment will be cancelled. Due to the volume of patients we see, we will be unable to reschedule your appointment for 6 months.
- Please call at least 24 hours before your scheduled appointment if you need to reschedule. Reschedules requested with less than 24 hours notice will be considered a No Show.
- Patients missing 3 appointments (No Shows) will be dismissed from our practice.
- You must arrive 10 minutes early for your appointment. Any patient who arrives 5 minutes after the scheduled appointment will not be seen and will need to reschedule their appointment.

  It is imperative that you confirm your or your child's appointment so we may plan our schedule accordingly. Please inform us of any phone number or address changes.

Signature: _____ Date: _____
(Parent/Guardian)

BEHAVIOR MANAGEMENT POLICY

Behavior Management allows for extra time and customized strategies to help patients successfully comply with restorative/hygiene treatment in clinical settings. Behavior Management requires another assistant to enter the room and help console a patient during treatment. Patients that utilize our cash payment plan will be charged a fee of $68.00 if behavior management is used during the time of service.

Signature: _____ Date: _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION
CONSENTIMIENTO PARA EL USO Y DIVULGACIÓN DE INFORMACIÓN DE SALUD

Patient Name: _____ Date Of Birth: _____

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information. A copy of our notice is provided upon request. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by requesting it from us.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we will decline to treat you or to continue treating you if you revoke this consent.

SIGNATURE

I, _____, have had fully opportunity to read and consider the content of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information as described in the "Notice of Privacy Practices."

Signature _____ Date_____
If this consent is signed by a personal representative on behalf of the patient, complete the following
Personal Representative's Name: _____

NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information.

As required by HIPPA we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing healthcare and related services by one of more health care providers. An example of this would be: Sending your patient records (clinical notes, treatment plan, and radiographs) to another provider via fax, mail, or email.
- Payment includes, but is not limited to, activities such as: obtaining reimbursement for services, confirming coverage, billing or collection activities and utilizations review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Healthcare operations are the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute identified health information by removing all reference to an individual or any individuals. We may contact you to provided appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest of you. All other uses and discloses will be made only with your written authorization. You may revoke the authorization in writing and we are required to honor and abide by that written request, except in relation to disclosures made prior to that date.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses, and disclosures, of protected health information, including information disclosed to family member, other relatives, close personal friends, or any other person you identify. We re, however, not required to agree to a requested restriction. If we do agree to restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable request to receive confidential communication of protected health information from s by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of November 28, 2006 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written compliant to our Privacy Officer, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPPA or to file a complaint:
The US Department of Health and Human Services
Office of Civil Rights
202-619-0257
Toll Free: 1-877-696-6775