



Patient Name: _____
Last First Middle

Patient's Date of Birth: _____

Name of Guardian: _____

Relationship: _____ Telephone _____

In case of emergency, contact _____ Phone # _____

POLICIES AND TREATMENT AGREEMENT

Please read and initial the following policies:

_____ Parent/Legal guardian must be present at all times while my child is receiving dental treatment. Patients without a parent/legal guardian present, or without a signed form assigning authorization, will not be seen and will be charged a broken appointment fee.

_____ It is my responsibility to bring my child to the Clinic at the date and time of his/her appointment. I must notify the Clinic at least 24 hours in advance if I need to cancel or re-schedule an appointment in order to avoid being charged a broken appointment fee.

_____ If I am late, I can potentially lose the time reserved for my child to be seen. This will be considered a broken appointment.

_____ After a 3rd missed appointment, I might become ineligible to have my child seen at the Clinic.

_____ I will provide my child's records showing Tuberculosis test results that are within the last 5 years and will provide an updated copy when requested. I understand the clinic staff is not obligated to call the medical office/school to obtain medical records.

_____ I understand that patients with a positive Tuberculosis skin test must provide a negative chest x-ray report and symptom review within the last 5 years indicating that the patient is free of any symptoms of Tuberculosis. Written evidence that treatment has been completed is also required.

_____ I will immediately report any health or medication changes to what has already been reported on my child's medical history form as well as any changes to the information previously provided to the Clinic, such as address, income or number of members in my family.

- _____ The Children's Dental Health Clinic accepts Medi-Cal, Public Private Partnership Program (PPP) and other government assisted dental insurances. For low-income families without insurance, we have a sliding scale fee payment program.
- _____ Patients with Medi-Cal must present their current insurance card in order to prove valid eligibility.
- _____ I understand I am responsible to pay for any dental treatment that is not covered or is denied by insurance. I am expected to pay on the day of the visit.
- _____ I grant permission to the Children's Dental Health Clinic to take any x-rays and/or perform dental prophylaxis necessary or advisable for my child's diagnostic and restorative treatment.
- _____ I hereby consent to the use of appropriate behavior guidance techniques during my child's treatment.
- _____ I hereby authorize the Children's Dental Health Clinic to use pictures/videotape taken of my child during treatment for brochures or other printed materials, website, or other ways that are needed by the CDHC. I understand that my child will not be identified by name.

The undersigned certifies that he/she has read and is willing to comply with the foregoing and is the parent or guardian of the patient.

Signature: _____ Date: _____
Parent/Guardian

Child's Name: _____ Date of Birth: _____ Age: _____

Address: _____ Zip: _____ Telephone: _____

In case of Emergency, contact: _____ Telephone: _____

Physician's Name (Medical Doctor): _____ Telephone: _____

1. Has your child had any history of, or conditions related to, any of the following:
- | | | |
|--|--|---|
| <input type="checkbox"/> Fainting spells or seizures | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hives or a skin rash |
| <input type="checkbox"/> Psychiatric treatment | <input type="checkbox"/> Persistent cough/cough up blood | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Stomach ulcers |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Heart disease/surgery | <input type="checkbox"/> Premature birth? # of weeks _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Intellectual disability | <input type="checkbox"/> Hypertension/high blood pressure | <input type="checkbox"/> Hepatitis, jaundice or liver disease |
| <input type="checkbox"/> Cleft lip or palate | <input type="checkbox"/> Bleeding disorder (Hemophilia/anemia/other) | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Hearing disability | <input type="checkbox"/> Sickle cell disease | <input type="checkbox"/> Kidney trouble |
| <input type="checkbox"/> Developmental disability | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Childhood cancer | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Inflammatory rheumatism | |

- | | Yes | No |
|---|--------------------------|--------------------------|
| 2. Is your child taking any prescription and/or over the counter medications at this time?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please list: _____ | | |
| 3. Is she taking oral contraceptives?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Is your child allergic to any medications?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please list: _____ | | |
| 5. Does your child have any environmental, food or other allergies?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please list: _____ | | |
| 6. Has your child ever been hospitalized or had a serious illness or operation? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please explain: _____ | | |
| 7. Does your child have to urinate more than six (6) times a day?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Is your child thirsty much of the time?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Has your child had abnormal bleeding associated with previous surgery, extractions or accidents? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Does he/she bruise easily? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has he/she ever required a blood transfusion?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Has your child had chemotherapy or radiation therapy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Does your child have a disability that may prevent treatment in a dental office?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please explain: _____ | | |
| 14. Is this the child's first visit to a dentist? | <input type="checkbox"/> | <input type="checkbox"/> |
| If not the first visit, what was the date of the last dentist visit? _____ | | |
| 15. Has your child had any problem with past dental treatments? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Has your child ever had dental radiographs (x-rays) taken? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Has he/she ever had orthodontic (braces) treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Has he/she ever been treated for any gum diseases? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Do his/her gums bleed when brushing teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Does he/she grind or clench teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Has he/she had toothaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Has he/she had frequent sores in his/her mouth?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Has he/she had any injuries to his/her mouth or jaws?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Does he/she have any sores or swelling of his/her mouth or jaws? | <input type="checkbox"/> | <input type="checkbox"/> |

To the best of my knowledge, all of the preceding answers are true and correct. If my child ever has a change in his/her health or medication, I will inform the doctor at the next appointment without fail.

Parent/Guardian Signature: _____ Date _____

Reviewed by: _____ Date _____ Reviewed by: _____ Date _____

CHILDREN'S DENTAL HEALTH CLINIC FINANCIAL SCREENING and AFFIDAVIT OF INCOME

How did you hear about our Clinic? _____

Patient Name: _____ Sex: M F
 Birthdate: ____/____/____ Age ____ Social Security # _____
 Address: _____ Apt. # _____
 City: _____ Zip Code: _____
 Home Phone Number: () _____ - _____ Cell Phone Number: () _____ - _____
 E-Mail Address: _____

Ethnic Group: Hispanic ___ White ___ Black ___ Asian ___ Amer. Indian ___ Other (Specify) _____
 Has child been treated here before? NO ___ YES ___ If yes, when? _____
 Does child have Medi-Cal? NO ___ YES ___ Card # _____
 Do you have dental insurance? NO ___ YES ___

| SOURCE OF INCOME: | FATHER (MONTHLY) | MOTHER (MONTHLY) | GUARDIAN/CAREGIVER (MONTHLY) |
|-------------------|------------------|------------------|------------------------------|
| WORK/EMPLOYMENT | \$ _____ | \$ _____ | \$ _____ |
| CHILD SUPPORT | \$ _____ | \$ _____ | \$ _____ |
| WELFARE | \$ _____ | \$ _____ | \$ _____ |
| UNEMPLOYMENT | \$ _____ | \$ _____ | \$ _____ |
| DISABILITY | \$ _____ | \$ _____ | \$ _____ |
| OTHER | \$ _____ | \$ _____ | \$ _____ |
| TOTAL | \$ _____ | \$ _____ | \$ _____ |

Family size _____

I certify that I have answered these questions accurately and truthfully to the best of my knowledge.

(PRINT) Name of person filling out forms: _____

Relationship to Patient: _____

SIGNATURE

_____/_____/_____
DATE

Is your household headed by a female or single mother?

Yes No

I understand I am responsible to pay any dental treatment that is not covered or is denied by insurance. My sliding scale rate is determined to be _____% of the usual and customary rate (UCR) per procedure. I understand payment is due the day service is rendered. The Children's Dental Health Clinic does not offer credit. If I am unable to keep my appointment, I will call to re-schedule at least one day in advance. Failure to do so may result in a broken appointment fee.

SIGNATURE OF RESPONSIBLE PERSON

_____/_____/_____
DATE

OFFICE USE ONLY

WITNESS SIGNATURE

_____/_____/_____
DATE

TOTAL FAMILY INCOME (MONTHLY) _____

HUD Pov. Level EXT-LW VL L

Policies and Regulations Reminders:

1. Please bring in your child's current Medi-Cal insurance identification card and a picture I.D. for both parent and patient.
2. Please call us at least 24 hours in advance if you need to cancel or change an appointment in order to avoid being charged for a broken appointment.
3. Please be on time. Arriving late will be considered a broken appointment, and you will be charged a broken appointment fee.
4. You are responsible for any procedure fee not covered by your insurance.
5. Please make sure anyone bringing the patient is the legal parent or has legal guardianship papers from the court or a notarized letter from the parent giving authorization for dental treatment.

Thank you for your cooperation.

CHILDREN'S DENTAL HEALTH CLINIC

Signature _____

Date ____ / ____ / ____

Clinic Witness _____

Date ____ / ____ / ____