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 for the initial visit and recall visit and cannot leave the waiting area while child is being treated. Patients without a parent/legal guardian present, or without a signed form assigning authorization will not be seen.

____ 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 you have Denti-Cal a missed or broken appointment can be reported to Medi-Cal.

____ If I am late, or do not confirm my appointment I can potentially lose the time reserved for my child to be seen or have my appointment cancelled. 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 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 and some PPO insurances. For low-income families without insurance, we have sliding scale fees when providing proof income.

____ 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:

☐ Fainting spells or seizures	☐ Asthma	☐ Hives or a skin rash
☐ Psychiatric treatment	☐ Persistent cough/cough up blood	☐ Arthritis
☐ Autism	☐ Tuberculosis (TB)	☐ Stomach ulcers
☐ Cerebral Palsy	☐ Emphysema	☐ Pregnancy
☐ Rheumatic fever	☐ Heart disease/surgery	☐ Premature birth? # of weeks _____
☐ Epilepsy	☐ Heart murmur	☐ Venereal disease
☐ Intellectual disability	☐ Hypertension/high blood pressure	☐ Hepatitis, jaundice or liver disease
☐ Cleft lip or palate	☐ Bleeding disorder (Hemophilia/anemia/other)	☐ Diabetes
☐ Hearing disability	☐ Sickle cell disease	☐ Kidney trouble
☐ Developmental disability	☐ HIV/AIDS	☐ Spina Bifida
☐ Hay fever	☐ Childhood cancer	☐ Other _____
☐ Thyroid disease	☐ Inflammatory rheumatism	

	Yes	No
2. Is your child taking any prescription and/or over the counter medications at this time?	☐	☐
If yes, please list: _____		
3. Is she taking oral contraceptives?	☐	☐
4. Is your child allergic to any medications?	☐	☐
If yes, please list: _____		
5. Does your child have any environmental, food or other allergies?	☐	☐
If yes, please list: _____		
6. Has your child ever been hospitalized or had a serious illness or operation?	☐	☐
If yes, please explain: _____		
7. Does your child have to urinate more than six (6) times a day?	☐	☐
8. Is your child thirsty much of the time?	☐	☐
9. Has your child had abnormal bleeding associated with previous surgery, extractions or accidents?	☐	☐
10. Does he/she bruise easily?	☐	☐
11. Has he/she ever required a blood transfusion?	☐	☐
12. Has your child had chemotherapy or radiation therapy?	☐	☐
13. Does your child have a disability that may prevent treatment in a dental office?	☐	☐
If yes, please explain: _____		
14. Is this the child's first visit to a dentist?	☐	☐
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?	☐	☐
16. Has your child ever had dental radiographs (x-rays) taken?	☐	☐
17. Has he/she ever had orthodontic (braces) treatment?	☐	☐
18. Has he/she ever been treated for any gum diseases?	☐	☐
19. Do his/her gums bleed when brushing teeth?	☐	☐
20. Does he/she grind or clench teeth?	☐	☐
21. Has he/she had toothaches?	☐	☐
22. Has he/she had frequent sores in his/her mouth?	☐	☐
23. Has he/she had any injuries to his/her mouth or jaws?	☐	☐
24. Does he/she have any sores or swelling of his/her mouth or jaws?	☐	☐

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 _____

Nombre del niño: _____ Fecha de nacimiento: _____ Edad: _____
Domicilio: _____ Zona Postal: _____ Telefono: _____
En Caso de Emergencia llamar a: _____ Telefono: _____
Nombre de su médico familiar: _____ Telefono: _____

1. Por favor indique solamente si alguna vez su hijo/a ha experimentado alguno de los siguientes:

☐ Desmayos o ataques	☐ Asma	☐ Sarpullido o dermatitis
☐ Tratamiento psiquiátrico	☐ Tos persistente o sangrado al toser	☐ Artritis
☐ Autismo	☐ Tuberculosis (TB)	☐ Ulceras gastricas
☐ Paralisis Cerebral	☐ Emfisema	☐ Embarazo
☐ Fiebre Reumática	☐ Enfermedad del corazón /cirugía	☐ Parto prematuro? # de semanas____
☐ Epilepsia	☐ Soplo cardíaco	☐ Enfermedades venereas
☐ Incapacidad física o mental	☐ Hipertensión/alta presión arterial	☐ Hepatitis o enfermedades del higado
☐ Labio leporino o paladar hendido	☐ Discrasias sanguineas (hemophilia/anemia/otro)	☐ Diabetes
☐ Problema de los oídos	☐ Enfermedad de las células falciformes	☐ Problemas renales
☐ Impedimentos fisicos	☐ SIDA (HIV/AIDS)	☐ Spina Bifida
☐ Alergias al polen	☐ Cáncer infantil	☐ Otros _____
☐ Enfermedad de la Tiroides	☐ Reumatisimo inflamatorio	

	Si	No
2. Esta su hijo/a tomando alguna medicina?	☐	☐
Si es así, explique: _____		
3. Su hija está tomando pastillas anticonceptivas?	☐	☐
4. Tiene su hijo/a alergias a algunas medicinas?	☐	☐
Si es así, explique: _____		
5. Tiene su hijo/a alergias ambientales, a alimentos, o otros?	☐	☐
Si es así, explique: _____		
6. Su hijo/a ha tenido una enfermedad seria, o ha sido hospitalizado u operado?	☐	☐
Si es asi, explique: _____		
7. Orina su hijo más de seis (6) veces al día?	☐	☐
8. Esta su hijo/a sediento la mayor parte del tiempo?	☐	☐
9. Tiene o ha tenido su niño sangrado anormal o excesivo, asociado con cirugía previa, extracciones dentales o accidentes?	☐	☐
10. Se le forman moretones fácilmente?	☐	☐
11. Alguna vez ha requerido trasfusiones de sangre?	☐	☐
12. Ha recibido su hijo/a terapia de radiación o quimioterapia?	☐	☐
13. Tiene su hijo/a alguna incapacidad física que pueda impedir tratamiento en una clínica dental?	☐	☐
Si es asi, explique: _____		
14. Es esta la primera visita al dentista de su hijo/a?	☐	☐
Si no, cual es la fecha de la última visita con el dentista? _____		
15. Ha tenido su hijo/a algún problema relacionado con previos tratamientos dentales?	☐	☐
16. Le han tomado radiografías dentales a su hijo/a anteriormente?	☐	☐
17. Ha recibido su hijo/a tratamiento de ortodoncia o frenos?	☐	☐
18. Ha sido su hijo/a alguna vez atendido por enfermedades de las encías?	☐	☐
19. Sangran sus encías cuando se cepilla los dientes?	☐	☐
20. Rechina sus dientes?	☐	☐
21. Ha tenido su hijo/a dolor de dientes?	☐	☐
22. Se le forman ulceras en su boca frecuentemente?	☐	☐
23. Ha sufrido su hijo/a alguna fracturas en la boca o quijada?	☐	☐
24. Tiene dolor o inflamación en su boca o quijada?	☐	☐

A mi mejor saber y entender, todas las respuestas anteriores son verdad y correctas. SI hay un cambio de salud o medicamentos de mi hijo/a, le informare al doctor en la próxima cita sin falta alguna.
Firma del padre, madre o tutor: _____ Fecha _____

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

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

How did you hear about our Clinic? _____ ***Sex: Male ☐ Female ☐***

Patient Name: _____

Birthdate: ____/____/____ Age _____ Social Security # _____

Address: _____ Apt. # _____

City: _____ Zip Code: _____

Home Phone Number: ( ) _____ - _____ Cell Phone Number: ( ) _____ - _____

E-Mail Address: _____

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 ____

List all household members		Age	Check all that Apply	Relationship to Head of Household	Annual Income Check all that Apply
Head of Household			☐Disabled ☐Senior	☐Female ☐Male	$_____ ☐Other_____ ☐Employed ☐Retired ☐Unemployed
Name of Member 2			☐Disabled ☐Senior		$_____ ☐Other_____ ☐Employed ☐Retired ☐Unemployed
Name of Member 3			☐Disabled ☐Senior		$_____ ☐Other_____ ☐Employed ☐Retired ☐Unemployed
Name of Member 4			☐Disabled ☐Senior		$_____ ☐Other_____ ☐Employed ☐Retired ☐Unemployed
Name of Member 5			☐Disabled ☐Senior		$_____ ☐Other_____ ☐Employed ☐Retired ☐Unemployed
Name of Member 6			☐Disabled ☐Senior		$_____ ☐Other_____ ☐Employed ☐Retired ☐Unemployed
Name of Member 7			☐Disabled ☐Senior		$_____ ☐Other_____ ☐Employed ☐Retired ☐Unemployed
Name of Member 8			☐Disabled ☐Senior		$_____ ☐Other_____ ☐Employed ☐Retired ☐Unemployed

Family Size _____

1. Ethnic Background (Check One): ☐Hispanic ☐No-Hispanic
2. Racial Background (Check One):

	White		American Indian / Alaskan Native & White
	Black / African American		American Indian / Alaskan Native & Black
	Asian		Asian & White
	American Indian / Alaskan Native		Black & White
	Native Hawaiian / Pacific Islander		Other Multi-Racial

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.

(PRINT) Name of person filling out forms: _____

Relationship to Patient: _____

According to Title 18 , Section 1001 of the U.S. Code, it is a felony for any person to knowingly and willingly make a false or fraudulent statements to any department of the United States Government. I, the undersigned, hereby certify that all statements contained herein, are true and correct to the best of my knowledge and belief. I understand the information I provide in certification is subject to verification, and agree to provide necessary documentation if requested to do so.

Under the penalty of perjury, I certify that the above information is true and correct

_____ _____

Applicant Signature Date

OFFICE USE ONLY

_____ _____/_____/_____

WITNESS SIGNATURE DATE

TOTAL FAMILY INCOME (MONTHLY) _____

HUD Pov. Level ☐ EXT-LW ☐ VL ☐L