WEE Dental

PATIENT INFORMATION / INFORMACION DE PACIENTE

Last Name / Apellido	First Name / Primer Nombre	Middle Name / Medio Nombre	Maiden Name / Apellido Materno
Birthdate / Fecha de Nacimiento	Gender / Genero	Social Security No. / Seguro Social	Marital Status / Estado Civil
Mailing Address / Direccion de Correo	Apt # / # de Apartamento	Street Address / Direccion de Apartado Postal	
City / Ciudad	State / Estado	Zip / Codigo Postal	Home Phone / Telefono de Casa ( )
Occupation / Ocupacion	Employer Name / Nombre de Empleo	Employer Address / Domicilio de Empleo	
		Phone No. / Telefono ( )	

GUARANTOR INFORMATION (Person responsible for payment) / INFORMACION DE PARSONA RESPONSABLE POR PAGO

Last Name / Apellido	First Name / Primer Nombre	Middle Name / Medio Nombre	Maiden Name / Apellido Materno
Birthdate / Fecha de Nacimiento	Gender / Genero	Social Security No. / Seguro Social	Marital Status / Estado Civil
Mailing Address / Direccion de Correo	Apt # / # de Apartamento	Street Address / Direccion de Apartado Postal	
City / Ciudad	State / Estado	Zip / Codigo Postal	Home Phone / Telefono de Casa ( )
Occupation / Ocupacion	Employer Name / Nombre de Empleo	Employer Address / Domicilio de Empleo	
		Phone No. / Telefono ( )	

EMERGENCY INFORMATION (Person not residing in the same household) / INFORMACION EN CASO DE EMERGENCIA (Persona no viviendo en misma casa)

Relationship to Patient / Relacion con el Paciente	Last Name / Apellido	First Name / Primer Nombre	Middle Initial / Medio Nombre
Street Address / Domicilio	Apt. No. / Numero de Apartamento	City / Ciudad	State / Estado Zip / Codigo Postal
Home Phone or Cell / Telefono de Casa o Celular		Work Phone / Telefono de Empleo	

INSURANCE INFORMATION (List all insurance plans you have) / INFORMACION DE ASEGURANZA (Anote todos planes de aseguranza que tenga)

Name of Insurance Company #1 / Nombre de Compania de Aseguranza	Group No. / Numero de Grupo	Name of policy holder / Nombre de Asegurado	Social Security No. / Nombre de Seguro Social
Name of Insurance Company #2 / Nombre de Compania de Aseguranza	Group No. / Numero de Grupo	Name of policy holder / Nombre de Asegurado	Social Security No. / Nombre de Seguro Social
Name of Insurance Company #3 / Nombre de Compania de Aseguranza	Group No. / Numero de Grupo	Name of policy holder / Nombre de Asegurado	Social Security No. / Nombre de Seguro Social

See Next Page / Vea Siguiente Pagina →

CONDITIONS TO TREATMENT:

1. CONSENT TO TREATMENT: The undersigned hereby consents to the administration and performance of all diagnostics procedures and treatment which in the judgment of my physician, may be considered necessary or advisable. I further agree that if I decide to leave **Avenal** Community Health Center without the written consent of my attending physician, neither said physician nor **Avenal** Community Health Center shall be liable for the consequences of such action.

2. RELEASE OF INFORMATION: To the extent necessary to determine liability for payment and to obtain reimbursement I authorize **Avenal** Community Health Center to release portions of my records, including my medical records, to any person, organization, or agency which is or may be liable for all or any portion **Avenal** Community Health Center's charges including but not limited to insurance companies, health care service plans, worker's compensation, and government agencies. I also give **Avenal** Community Health Center permission to obtain medical records pertaining to treatment rendered at other facilities, i.e., hospitals and specialists, while under the care of a physician at **Avenal** Community Health Center.

3. MEDICARE ASSIGNMENT: I certify that the information given by me in applying for payment under Title XVIII of Social Security Act is correct. I request that payment of authorized benefits be made in my behalf.

4. ASSIGNMENT OF INSURANCE BENEFITS: In the event I am entitled to outpatient benefits arising out of any policy of insurance insuring me of any party liable to me, I hereby assign said benefits directly **Avenal** Community Health Center for application to my bill. I agree that **Avenal** Community Health Center may issue receipt of any such payment, that such payment shall discharge the insurance company of any and all obligations under the policy to the extent of the payment, and that I shall be responsible for charges not covered by this assignment.

5. FINANCIAL AGREEMENT: I hereby agree that in consideration for services to be rendered by **Avenal** Community Health Center, I shall make prompt payments to the account **Avenal** Community Health Center as bills are presented. I agree to pay interest at the legal rate should the account become delinquent, and if it becomes necessary for the account to be referred to an attorney for collections, I shall pay the actual attorney's fees and collection expenses.

6. GUARANTOR: I hereby agree to assume the obligations imposed by the "Financial Agreement" above.

7. TEACHING PROGRAM: To the extent that **Avenal** Community Health Center conducts teaching programs to which the patient's condition or treatment is pertinent, students shall be permitted to participate in the care of the patient unless **Avenal** Community Health Center is notified to the contrary in writing.

Date	Signature of Patient / Parent / Guardian	Relationship to Patient (if applicable)	Witness (office staff)

CONDICIONES DE TRATAMIENTO:

1. CONSENTIMIENTO PARA TRATAMIENTO: Por este medio el firmante consiente el administro y cumplimiento a todo procedimiento diagnostico, en que, en el juicio de mi medio podria ser necesario o aconsejable. Yo estoy de aquerdo que si yo decido salir de **Avenal** Community Health Center sere responsible las consequencias de semejante decision.

2. LIBERACION DE INFORMACION: En la extension necesaria para determinar responsabilidad para pago y obtener reembolso, yo autorizo **Avenal** Community Health Center que libere parte de mis documentos, incluso mis documentos medicos, a cualquier persona, organizacion, o agencia en que es o podria ser responsable por todo o parte de cargos de **Avenal** Community Health Center incluso pero limitado a companias de aseguranza, planes de servicios de salud, compensacion de trabajadores, y agnecias del govierno. Yo tanbien le doy permiso a **Avenal** Community Health Center que obtenga mis documentos medicos que tengan que ver con tratamiento que se me haga hecho en otras facilidades, por ejemplo, hospitales y especialistas mientras que estoy bajo del cuidado de medicos en **Avenal** Community Health Center.

3. ASIGNACION DE MEDICARE: Yo certifico que la informacion dada por mi en aplicare para pago el Titulo XVIII del acto de Seguro Social es correcto. Yo pido que pagos de autorizados beneficios se hagan de mi parte.

4. ASIGNACION DE BENEFICIOS DE ASEGURANZA: En el evento yo estoy en mi derecho para beneficios de paciente externo que se presente de cualquier polica de aseguranza que me asegura a mi o cualquier partido responsible a mi, yo por este medio assigno beneficios dichos directamente a **Avenal** Community Health Center por aplicacion a mi cuenta. Yo estoy de acuerdo que **Avenal** Community Health Center pueda emitir recibo de semejante pago, que semejante pago seran descargados a la compania de aseguranza de algun y toda obligaciones bajo la polica al alcanse del pago y que yo seria responsable por cargos no cubiertos por esta a asignacion.

5. ACUERDO FINANCIERO: Yo estoy de acuerdo que en consideracion de servicios probados en **Avenal** Community Health Center, yo cumplire en hacer pagos pronto en la cuenta de **Avenal** Community Health Center en cuanto se me presente los biles. Yo estoy de acuerdo en pagar intereses al la porporcion legal si mi cuenta seria delincuente, y necesario que se refiera un abogado para colecciones, yo pagaria la quota actual del abogado y gastos de colecciones.

6. GARANTE (FIADOR/A): En estos medios yo de aquerdo en tomar las obligaciones impuestas por el "Acuerdo Financiero" mencionado arriba.

7. PROGRAMA DE ENSENANZA: En el alcanse de que **Avenal** Community Health Center conducte programas de ensenanza donde la condicion del paciente o tratamiento sea pertinente, estudiantes seran permitidos a participar en el cuidado del paciente a menos que **Avenal** Community Health Center sea notificado en lo contrario en por escrito.

Fecha	Firma del Paciente / Padre / Guardiano	Relacion al Paciente	Testigo (Personal de Oficina)

We are required by the federal government to ask you these questions, and while it will be helpful if you answer them, you are <u>not required</u> to do so to receive healthcare services.

Acct# _____

PERSONAL & HOUSING

Patient Name: _____ **Today's Date:** _____

DOB: _____ **Age:** _____ **Gender at Birth:** ☐**Male** ☐**Female**

Patient Address: _____
Street City State ZIP

Phone # (_____)_____

How many families live at this address: ☐Just mine ☐More than just mine: If so, how many Families: ____ Persons: ____

At this address, I am the: ☐Owner or ☐Only Renter ☐Primary Renter ☐A sub renter ☐Not paying rent

If shared, do you live in or share: ☐A Room or ☐A Garage or ☐Another building at this address

OR I am Homeless: ☐On the Street ☐In a Homeless Shelter ☐Transitional Housing

What language are you best served in?
☐English ☐Sign Language ☐Spanish ☐Other _____

If appropriate, please indicate your current status with the United States Military: ☐Active Duty ☐Active Reserves ☐National Guard ☐Honorable Discharge ☐General Discharge ☐Other Discharge ☐Retired ☐Separated

ETHNICITY

Do you consider yourself to be of Hispanic or Latino identity *regardless of your race?*

☐**Yes, I consider myself Hispanic or Latino:**
I am of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, based on racial identification and including those born in the United States. Do *<u>not</u>* select if you are from Brazil or Haiti and your ethnicity is not tied to the Spanish language.

☐**No, I do NOT consider myself Hispanic or Latino:** All others

RACE

In addition to your Ethnicity, please clarify what Race(s) you identify yourself as (you may check more than one):

☐**Asian:** Persons having origins in any of the original peoples of the Far East, Near East, Southeast Asia or the Indian subcontinent including for example, Arabic Speaking countries, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, Thailand, and Vietnam.

☐**Asian - Philippine Islands:** Persons having origins in the peoples of the Philippine Islands.

☐**Native Hawaiian:** Persons having origins in any of the original peoples of Hawaii.

☐**Other Pacific Islanders:** Persons having origins in any of the original peoples of Guam, Samoa, Palau, Truk, or other Pacific Islands in Micronesia, Melanesia or Polynesia.

☐**Black / African American:** Persons having origins in any of the original peoples of Africa, including those born in the United States.

☐**American Indian:** Persons having origins in any of the original peoples of North, Central and South America, and who maintain tribal affiliation or community attachment.

☐**Alaskan Native:** Persons having origins in any of the original peoples of the Alaskan State or Territory, and who maintain tribal affiliation or community attachment.

☐**White:** Persons having origins in any of the original peoples of Europe & Eastern Europe, including those born in the USA.

EMPLOYMENT & INCOME

A. How many people are in your family? _____

B. What is your family income? _____ **per (circle one): week - month - year**

C. Have you or any wage earner in your family:
☐Yes ☐No Worked as a **Farmworker** during the past 2 years?
☐Yes ☐No Retired from **Farmwork** or
☐Yes ☐No Remain disabled from **Farmwork?**

D. If all answers in "C" are No, Skip "E". If yes, what is the relationship of the farmworker to the patient?
☐Self ☐Spouse ☐Parent ☐Child ☐Other _____

E. If an item in "C" is marked yes, are you or they (mark all that apply):
☐Migrant: During the past 2 years, you spent a night somewhere else to work?
☐Seasonal: Stay in one place but off work for more than 2 weeks every year?
☐Full Time: Never laid off from farmwork for more than 2 weeks during the past 2 years?

GENDER

1. Do you think of yourself as (check one):
☐Choose not to disclose ☐Straight or Heterosexual ☐Lesbian, Gay or Homosexual ☐Bisexual
☐Don't know ☐Something else _____

2. **With which gender do you identify? (check one):**
☐Choose not to disclose ☐Male ☐Female ☐Transgender Male (Female-to-Male)
☐Transgender Female (Male-to-Female) ☐Other

Signature _____ Date _____

Printed Name _____ Relation to Patient _____

Dental History

Patient Name: _____

Birth Date: _____

Has any close family member ever had a serious problem while having surgery under anesthetic? Yes No

Is the patient under the care of a physician? Yes No

If yes, name of physician _____ Phone _____

Is patient taking medication? Yes No

If yes, please list _____

Medical History

Does patient have or use any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Allergy to Penicillin/Amoxicillin	☐	☐	Down Syndrome	☐	☐	Cerebral Palsy
☐	☐	Radiation Treatment	☐	☐	Artificial Joint	☐	☐	Scarlet Fever
☐	☐	Excessive Bleeding from Cuts or Extractions	☐	☐	Diabetes	☐	☐	Sickle Cell Disease
☐	☐	Allergy to Tape	☐	☐	Kidney Problems	☐	☐	Emphysema
☐	☐	Allergy to Latex	☐	☐	Liver Problems	☐	☐	Epilepsy or Seizures
☐	☐	Any Heart Ailments	☐	☐	Chemical Dependency	☐	☐	Fainting or Dizzy Spells
☐	☐	Angina	☐	☐	Hepatitis A, B or C	☐	☐	Cold Sores
☐	☐	High Blood Pressure	☐	☐	Blood Transfusion	☐	☐	Allergies or Hives
☐	☐	Heart Murmur / Physician _____	☐	☐	Hemophilia	☐	☐	Arthritis
☐	☐	Congenital Heart Lesions	☐	☐	Malignancies or Leukemia	☐	☐	Rheumatism
☐	☐	Artificial Heart Valve	☐	☐	Psychiatric Care / Emotional Problems	☐	☐	Glaucoma
☐	☐	Heart Pacemaker	☐	☐	Extreme Nervousness / Apprehension	☐	☐	Pain in Jaw Joints
☐	☐	Stroke	☐	☐	Physical Handicap	☐	☐	Sinus Problems
☐	☐	Heart Surgery / Physician _____	☐	☐	Intellectual Disability	☐	☐	Thyroid Disorders
☐	☐	Anemia or Blood Problems	☐	☐	Mental Illness	☐	☐	Eye Disorders
☐	☐	Asthma	☐	☐	Immune System Disorders (AIDS, HIV, ARC)	☐	☐	Tonsillitis
☐	☐	Allergy to Other Drugs _____	☐	☐	Sexually Transmitted Infections	☐	☐	Ulcer or Colitis
☐	☐	Allergy to Anesthetics _____	☐	☐	Yellow Fever	☐	☐	Tuberculosis (TB)
☐	☐	Hay Fever or Allergies in General	☐	☐	Rheumatic Fever	☐	☐	Gags Easily
☐	☐	Cortisone Medicine	☐	☐	Allergy to Red Dye	☐	☐	Any Other Medical Condition
☐	☐	Autistic	☐	☐	Behind on Immunizations			_____

To the best of my knowledge, all the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will without fail, inform the doctor at my next appointment.

Patient/Guardian Signature: _____ Date: _____

Aria Community Health Center

1000 Skyline Blvd. • P.O. Box 700 • Avenal, CA 93204 • Ph. 559-386-4500 • Fax 559-386-0550

a california health center

DENTAL DEPARTMENT MISSED APPOINTMENT AGREEMENT

We value you as our patient and need your cooperation with keeping appointments so that we can provide your care. Missing or canceling an appointment with less than 24 hours notice means we are unable to fill this appointment time with another patient who urgently needs care.

Our policy requires:

Appointment courtesy call: We will contact you two days before your scheduled appointment to remind you that you have an appointment. If we are unable to reach you in person, we may give your appointment away to another patient.

Initials ☐

Timely Cancellations: If you need to cancel or reschedule your appointment, you must give us at least 24 hours notice. **Cancellations made with less than 24 hours notice will be considered a missed appointment.**

Initials ☐

On Time Arrivals: If you are more than 10 minutes late to your appointment, we may need to reschedule you for another time. The result of this action is that it will be marked as a missed appointment.

Initials ☐

Compliance: Patients are allowed ***three missed appointments***. After the ***third missed appointment***, you will be dismissed as our patient and be placed on "same day" only status.

Initials ☐

Many patients use Avenal Community Health Center Dental services. Your help in keeping your appointments enables us to reduce your wait time when you come in for dental care.

_____

Name

_____ _____

Patient or Parent/Guardian Signature Date

Patient Acknowledgment of
Receipt of Dental Materials Fact Sheet

I, _____, Acknowledge I have received from WEE Dental a copy of the Dental Materials Fact Sheet dated October 2001.

_____ _____
Patient Signature *Date*

- -

Yo, _____, Certifico que reciví departe de Avenal Community Health Center una copia sobre la hoja de información Material Dental con la fecha de octubre 2001.

_____ _____
Firma de paciente *La fecha*

The following document is the Dental Board of California's Dental Materials Fact Sheet. The Department of Consumer Affairs has no position with respect to the language of this Dental Materials Fact Sheet; and its linkage to the DCA web site does not constitute an endorsement of the content of the document.

The Dental Board of California
Dental Materials Fact Sheet
Adopted by the Board on October 17, 2001

As required by Chapter 801, Statutes of 1992, the Dental Board of California has prepared this fact sheet to summarize information on the most frequently used restorative dental materials. Information on this fact sheet is intended to encourage discussion between the patient and dentist regarding the selection of dental materials best suited for the patient's dental needs. It is not intended to be a complete guide to dental materials science.

The most frequently used materials in restorative dentistry are amalgam, composite resin, glass ionomer cement, resin-ionomer cement, porcelain (ceramic), porcelain (fused-to-metal), gold alloys (noble) and nickle or cobalt-chrome (based-metal) alloys. Each material has its own advantages and disadvantages, benefits and risks. These and other relevant factors are compared in the attached matrix titled "Comparisons of Restorative Dental Materials." "A Glossary of Terms" is also attached to assist the reader in understanding the terms used.

The statements made are supported by relevant, credible dental research published mainly between 1993 - 2001. In some cases, where contemporary research is sparse, we have indicated our best perceptions based upon information that predates 1993.

The reader should be aware that the outcome of dental treatment or durability of a restoration is not solely a function of the material from which the restoration was made. The durability of any restoration is in influenced by the dentist's technique when placing the restoration, the ancillary materials used in the procedure, and the patient's cooperation during the procedure. Following restoration of the teeth, the longevity of the restoration will be strongly influenced by the patient's compliance with dental hygiene and home care, their diet and chewing habits.

Avenal Community Health Center/WEE Dental
1000 Skyline Boulevard • P.O. Box 700 • Avenal, CA 93204-0700 • Phone (559) 386-4500 • FAX (559) 386-0550

General Consent for Treatment

Patient Name:	ID:	DOB:	Gender: M or F

Please review the consent for treatment below. If you have questions, PLEASE ASK YOUR DOCTOR.

☐ I give consent for myself/my child to receive dental treatment deemed necessary by the providers of Avenal Community Health Center. These procedures include, but are not limited to:

- Examinations
- Oral Prophylaxes (Cleanings)
- Fluoride treatments
- Sealants
- Restorations (Amalgam or Composite Fillings and Crowns)
- Periodontal (Gum) treatments
- Endodontic (Root Canal) treatments
- Extractions
- The use of Local Anesthetics
- Conscious Oral Sedation

I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia. This consent shall be considered in effect until rescinded or revoked.

THIS SECTION NEEDS TO BE COMPLETED FOR CHILDREN UNDER THE AGE OF 18 BY A PARENT OR LEGAL GUARDIAN ONLY.

☐ I affirm that I am the parent or legal guardian of minor child, _____, If I am unable to accompany child, I give permission for the individuals named below to escort my child for dental treatments:

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

HIPAA Notification Acknowledgement

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgement" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

This consent shall be considered in effect until rescinded or revoked

Patient/Legal Guardian: _____ Date: _____

Relationship: _____

Staff: _____ Date: _____