Medical & Dental History

Patients Name: _____ DOB: _____/_____ /_____ Age: _____
(Legal First Name, Middle Initial, Last Name) (MM/DD/YYYY)

Sex: ☐ Male ☐ Female ☐ Other: _____ Social Security Number: _____-_____-_____

Address: _____ Apt: _____ City: _____ Zip Code: _____

Primary Phone Number: (_____) _____-_____ Secondary Phone Number: (_____) _____-_____

Emergency Contact: _____ Phone Number: (_____) _____-_____ Relationship: _____

If we cannot get a hold of the parent or guardian, can we confirm appointments with the emergency contact?

☐ Yes ☐ No

Physician's Name (Medical Doctor): _____ Phone Number: (_____) _____-_____

How did you hear about our Dental Clinic? _____

Has the patient had a history of, or conditions related to any of the following?

Check all that apply.

☐ Autism
☐ Psychiatric treatment
☐ Anxiety/Depression
☐ Down Syndrome
☐ Cerebral Palsy
☐ Fainting spells or seizures
☐ Epilepsy
☐ Intellectual/developmental disability
☐ Cleft lip or palate
☐ Spina Bifida
☐ Hearing Problems
☐ Vision Impaired
☐ Asthma
☐ Lung Disease
☐ Tuberculosis (TB)
☐ Rheumatic Fever
☐ Heart disease/surgery
☐ Heart murmur
☐ Blood disorder
☐ Sickle cell disease
☐ Kidney Disease
☐ HIV/AIDS
☐ Childhood cancer/tumors
☐ COVID-19 Date:
☐ Hives or a skin rash
☐ Arthritis
☐ Stomach problems/ulcers
☐ Pregnancy
☐ Premature birth? # of weeks ____
☐ Sexually Transmitted Disease
☐ Hepatitis, jaundice or liver disease
☐ Diabetes
☐ Thyroid disease
☐ Hypertension/high blood pressure
☐ Other_____
_____

Mark Yes or No for the following questions.

	Yes	No
1. Is the patient taking any prescription or over the counter medications at this time? Please list: _____	☐	☐
2. Is the patient taking oral contraceptives?	☐	☐
3. Is the patient allergic to any medications? Please list: _____	☐	☐
4. Does the patient have any food, seasonal, and/or other allergies including latex products? Please list: _____	☐	☐
5. Has the patient been hospitalized, had a serious illness or operation? Specify: _____	☐	☐
6. Has the patient had abnormal bleeding associated with previous surgeries, extractions or accidents?	☐	☐
7. Has the patient ever required a blood transfusion?	☐	☐
8. Has the patient had chemotherapy or radiation therapy?	☐	☐
9. Does the patient have a disability that may affect treatment in a dental office? Specify: _____	☐	☐

	Yes	No
10. Is this the patient's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? _____	☐	☐
11. Has the patient had any problems with past dental treatments?	☐	☐
12. Has the patient ever had orthodontic (braces) treatment?	☐	☐
13. Has the patient ever had injuries to his/her mouth or jaws?	☐	☐
14. Does the patient have any pain, sores or swelling of his/her mouth or jaws?	☐	☐
15. Does the patient use recreational marijuana or CBD (Edibles)?	☐	☐

WHAT IS THE REASON FOR THE VISIT TODAY? _____

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

If the patient is under 18 years old, parent/legal guardian must sign

Print Name: _____ Relationship: _____

Signature: _____ Date: _____/_____/_____
(MM/DD/YYYY)

Financial Screening

Patients Name: _____ DOB: _____/_____/_____
(Legal First Name, Middle Initial, Last Name) (MM/DD/YYYY)

Email Address: _____ Can we confirm appointments via Email? ☐ Yes ☐ No

Does the patient have Medi-Cal? ☐ Yes ☐ No **Member ID/ ID No.: 9_____**

Does the patient have any other Dental Insurance? (Other than Medi-Cal) ☐ Yes ☐ No

If yes, please provide the following:

Subscriber Name: _____

Subscriber DOB: ____/____/____

Subscriber Social Security Number: _____-_____-_____

Insurance Company: _____ Phone Number: (_____) _____-_____

ID #: _____

Group Number: _____

Employer: _____

Signature:_____Date: _____/_____/_____
(Parent /Legal Guardian Signature) (MM/DD/YYYY)

I hereby give permission to The Children's Dental Health Clinic to obtain information for the patient listed above for benefit and insurance eligibility.

Demographics

Patient Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Patient Race (mark all that apply):

☐ American Indian / Alaskan Native	☐ White (Caucasian)
☐ Asian	☐ Native Hawaiian/ Pacific Islander
☐ Black / African American	☐ Multi-Racial

Household Information

Head of Household Name: _____ Relationship: _____
(Legal First Name and Last Name)

Head of Household Sex: ☐ Male ☐ Female ☐ Other: _____

Household Size: _____

Family household Income: $_____ Monthly / Yearly

Initial the following.

_____ I understand, I am responsible to pay for any dental treatment not covered by my insurance/ Denti-cal. My rate will be determined based on verified household income. If I am unable to provide proof of income, I am responsible to pay the highest fee rate. All Payments are due on the day services are rendered.

**Income is verified with recent paystub, Tax forms, or letter from employer

Fee Level

Level	A	B	C	D	E	F	G
Percentage (Paid by Patient)	Pay 15%	Pay 25%	Pay 30%	Pay 35%	Pay 55%	Pay 65%	Pay 80%

It is a felony to knowingly and willingly make false or fraudulent statements or conceal information. I, the undersigned, hereby certify that all statements contained herein, are true and correct to the best of my knowledge. I understand the information I provide in certification is subject to verification, and agree to provide necessary documentation if requested to do so.

"A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable."

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

Name: _____ Relationship: _____
(Legal First Name and Last Name)

Signature:_____Date: _____/_____/_____
(MM/DD/YYYY)

OFFICE USE ONLY

Witness Signature: _____ Date: _____/_____/_____
(MM/DD/YYYY)

Household Income (Monthly): $_____

HUD POV. LEVEL: ☐ EXT-LOW ☐ V-LOW ☐ LOW

FEE LEVEL: ☐ A ☐ B ☐ C ☐ D ☐ E ☐ F ☐ G

Policies and Treatment Agreement

Patient Name: _____DOB: _____/_____/_____
(Legal First Name, Middle Initial, Last Name) (MM/DD/YYYY)

Please read and initial the following policies.

_____ A parent/legal guardian must accompany the patient for the first dental visit and follow-up visits. A parent/legal guardian is the only person authorized to sign treatment plans and consents. The Parent/legal guardian must stay within the clinic while patient is undergoing treatment.

_____ Patients under 18 years old must be present with a parent/ legal guardian or an authorized caretaker (form must be filled out prior to any appointment). Any adult accompanying the patient must have a valid proof of identification to be present during any dental visit.

_____ Patient forms are required to be filled out by a parent/legal guardian every 6 months or sooner if there are changes to the health of the patient. The Children's Dental Health Clinic (CDHC) must be notified of any changes of the household such as, contact information, address, household income, and family size.

_____ Patients are required to attend their appointments on time in order to be seen. All appointments must be confirmed 24 hours in advance, otherwise the appointment could be canceled. You are required to give us a 24-hour notice if the appointment needs to be canceled or rescheduled to avoid a broken appointment fee.

_____ After a 3rd missed appointment; the patient is no longer eligible to return to CDHC. Missed appointments could be reported to Medi-Cal.

_____ The Children's Dental Health Clinic only accepts cash, Medi-Cal and some PPO insurances. We are out of network with PPO insurances. Patients must present their State of California Benefits Identification Card or insurance card in order to prove valid eligibility.

_____ The responsible party is required to pay for any dental treatment not covered or denied by Medi-Cal or Insurance. CDHC offers Sliding scale fees for low-income families when providing proof of household income. Payment is due on the appointment day.

_____ The Children's Dental Health Clinic has permission to take x-rays and or perform dental prophylaxis necessary or advisable for the patient's diagnostic and restorative treatment.

_____ The Children's Dental Health Clinic is a non-profit teaching institution. Dental Residents in Pediatric Dentistry and Oral Surgery may provide care to the patient under direct supervision of an attending Dentist. Allied health personnel such as senior dental hygiene students and dental assistants may provide care to the patient under direct supervision of the attending faculty.

_____ The Children's Dental Health Clinic is authorized to use pictures/videotapes taken of the patient during treatment for brochures or other printed materials, websites, or other ways that are needed by CDHC. The patient's identity will maintain confidential.

I, the undersigned, certify that I have read and am willing to comply with the above.

Print Name: _____ Relationship: _____

Signature: _____ Date: _____/_____ /_____
(MM/DD/YYYY)