



### Medical & Dental History

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

Prefers to be called/Nickname: \_\_\_\_\_

Gender:  Male  Female Patients Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Gender Identity (if different from above):

Trans male/Trans man  Trans female/Trans woman  Gender non-confirming  Other \_\_\_\_\_

Address: \_\_\_\_\_ Apt: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Phone Number: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Secondary Phone Number: (\_\_\_\_) \_\_\_\_-\_\_\_\_

#### Emergency Contact

Name: \_\_\_\_\_ 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/Referred By? \_\_\_\_\_

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

Check all that apply.

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

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?<br>Please list: _____       | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Is the patient taking oral contraceptives?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Is the patient allergic to any medications?<br>Please list: _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Does the patient have any food, seasonal, and/or other allergies including latex products?<br>Please list: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Has the patient been hospitalized, had a serious illness or operation?<br>Specify: _____                         | <input type="checkbox"/> | <input type="checkbox"/> |



- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 6. Has the patient had abnormal bleeding associated with previous surgeries, extractions or accidents?                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Has the patient ever required a blood transfusion?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Has the patient ever had any disciplinary problems at school?<br>Specify: _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Has the patient had chemotherapy or radiation therapy?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Does the patient have a disability that may affect treatment in a dental office?<br>Specify: _____                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Is this the patient's first visit to a dentist?<br>If not the first visit, what was the date of the last dentist visit? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Has the patient had any problems with past dental treatments?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Has the patient ever had orthodontic (braces) treatment?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Has the patient ever had injuries to his/her mouth or jaws?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Does the patient have any pain, sores or swelling of his/her mouth or jaws?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Does the patient use recreational marijuana or CBD (Edibles)?   | <input type="checkbox"/> | <input type="checkbox"/> |

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: \_\_\_\_\_  
(Legal First Name and Last 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 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 or Latino  Non-Hispanic or non-Latino  I decline to answer

Patient Race (mark all that apply):

<input type="checkbox"/> American Indian / Alaskan Native	<input type="checkbox"/> White (Caucasian)
<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian/ Pacific Islander
<input type="checkbox"/> Black / African American	<input type="checkbox"/> Multi-Racial
<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> I decline to answer

Primary language spoken in household: \_\_\_\_\_

Housing Status:  Housed  Housing insecure  Homeless



**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

**Sliding Fee Scale**

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
<b>Percentage</b> (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)

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 3<sup>rd</sup> 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: \_\_\_\_\_  
(Legal First Name and Last Name)

Relationship: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(MM/DD/YYYY)