Patient Name_____ **Chart #**_____
DOB _____ **Acct. #** _____

GENERAL DENTISTRY PATIENT CONSENT FORM

In reading and signing this form it is understood that ENGLISH is the language that I understand and use to communicate.

( ) 1. DRUGS, MEDICATIONS, AND ANESTHESIA:

I understand that antibiotics, analgesics, and other medications may cause adverse reactions, some of which are, but are not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest.

I understand that medications, drugs, and anesthetics may cause drowsiness and lack of coordination, which can be increased by the use of alcohol or other drugs. I have been advised not to consume alcohol, nor operate any vehicle or hazardous device while taking medications and/or drugs, or until fully recovered from their effects (this includes a period of at lease twenty-four (24) hours after my release from surgery.

I understand that occasionally, upon injection of a local anesthetic, I may have prolonged, persistent anesthesia, numbness, and /or irritation to the area of injection.

I understand that if I select to utilize Nitrous Oxide, "Atarax", Chloryl Hydrate, "Zanax", or any other sedative, possible risks include, but are not limited to, loss of consciousness, obstruction of airway, anaphylactic shock, and cardiac arrest. I understand that someone needs to drive me home from the dental office after I have received sedation. I also understand that someone needs to watch me closely for a period of 8 to 10 hours, following my dental appointment, to observe for possible deleterious side effects, such as obstruction of airway.

( ) 2. HYGIENE AND PERIODONTICS (TISSUE AND BONE LOSS):

I understand that the long-term success of treatment and status of my oral condition depends on my efforts at proper oral hygiene (i.e. brushing and flossing) and maintaining regular recall visits.

PERIODONTICS-I understand that I have a serious condition, causing gum and bone inflammation and/or loss, and that it can lead to loss of my teeth and other complications. The various treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I also understand that although these treatments have a high degree of success, they cannot be guaranteed. Occasionally, treated teeth may require extraction.

( ) 3. FILLINGS:

I have been advised of the need for fillings, either silver or composite (plastic), to replace tooth structure lost to decay I understand that with time fillings will need to be replaced due to wearing of material. In cases where very little tooth structure remains or existing tooth structure fractures off, I may need to receive more extensive treatment (such as root canal therapy, post and build-up, and crowns), which would necessitate a separate charge.

I understand that the silver amalgam restoration is an acceptable procedure according to the American Dental Association guidelines and, as such, is a treatment used by your dentist. The advantages of alternate materials have been explained to me.

( ) 4. DENTURES COMPLETE OR PARTIAL:

The problems of wearing dentures had been explained to me including looseness, soreness, and possible breakage, and relining due to tissue change. Follow-up appointments are an integral part of maintenance and success of a prosthetic appliance. Persistent sore spots should be immediately examined by the doctor.

I further understand that surgical intervention (i.e. tori(bone) removal, bone recontouring, or implants) may be needed for dentures to be properly fitted. I also understand that due to bone loss or other complicating factors, I may never be able to wear dentures to my satisfaction.

( ) 5. PEDODONTICS (CHILD DENTISTRY):

I understand that the following procedures are routinely used at this dental office, as well as being accepted procedures in the dental profession.

A. POSITIVE REINFORCEMENT- Rewarding the child who portrays desirable behavior, by use of compliments, praise, a pat or hug, and/or token objects or toys.
B. VOICE CONTROL- The attention of a disruptive child is gained by changing the tone or increasing the volume of the doctor's voice.

C. PHYSICAL RESTRAINT- Restraining the child's disruptive movements by holding down their hands, upper body, head, and/or legs by use of the dentist's or assistant's hand or arm, or by use of a special device (referred to as a "papoose board").
D. NITROUS OXIDE AND/OR ORAL SEDATION- Nitrous Oxide is a mild gas that is mixed with oxygen, and is used to sedate a person. It is administered through a mask placed over the child's nose. Oral sedations are medications administered to children to help them relax. With their use the parent/or guardian must understand that the child should not eat or drink for a period of four hours prior to the sedation appointment. The parent/guardian must be available to escort the child home after the sedation procedure, and observe their behavior throughout the day.

I understand that with the use of an injection, used to numb the tooth for dental procedure, the possibility exists that the child may inadvertently bite their lip causing injury to occur.
I understand the need to return to the office, for evaluation, if swelling and/or pain in my child does not go away after a sufficient period of time.
I understand the need to return to the office within three months following nerve treatment of a "baby tooth" for evaluation, and the possibility of it then needing an extraction.

I understand that any portion of my dental record shall be open for inspection by the State, insurers, and other regulatory or clinical agencies upon request will be provided access to all data collected under the terms of their contracts with Clinica de Salud. These records and data will be subject to fiscal and program audits and will not be public in any manner which allows identification of any individual.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information, I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how may private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I UNDERSTAND THAT NO GUARANTEE OR ASSURANCE HAS BEEN GIVEN THAT THE PROPOSED TREATMENT WILL BE CURATIVE AND/OR SUCCESSFUL TO MY COMPLETE SATISFACTION. I AGREE TOP COOPERATE COMPLETELY WITH THE RECOMMENDATIONS OF THE DOCTOR WHILE I AM UNDER HER/HIS CARE, REALIZING THAT ANY LACK OF SAME COULD RESULT INLESS THAN OPTIMUM RESULTS.

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE, INCLUDING THE OPPOSING SIDE OF THE DOCUMENT, AND CONSENT TO THE OPERATION AND EXPLANATION REFERRED TO OR MAKE. I HAVE BEEN ENCOURAGED TO ASK QUESTIONS, AND HAVE HAD THEM ANSWERED TO MY SATISFACTION.

I UNDERSTAND THESE DENTAL SERVICES ARE PROVIDED WITHOUT DISCRIMINATION BASED ON RACE, RELIGION, COLOR, NATIONAL ORGIN, SEX, SEXUAL ORIENTATION, PHYSICAL OR MENTAL DISABILITY, AGE OR MARITAL STATUS AND PROTECTS THE PRIVACY OF EACH OF ITS PATIENTS.

Signature:_____
Patient or Legal Representative

Relationship:_____ Date:____/____/____

Doctor:_____Witness:_____

CLINICA DE SALUD DEL VALLE DE SALINAS
Patient Information

Date:_____ MRN:_____
Account #: _____

Preferred Language: ☐ English ☐ Spanish ☐ Other:_____
Do you have a language barrier? ☐ Yes ☐ No
Place of Birth:_____

Last Name	First Name	Middle Initial
Date of Birth	Social Security Number	Phone Number

Ethnicity	Email	Sex
☐ Hispanic ☐ Black ☐ White ☐ Other:_____		☐ F ☐ M

Gender Identity ☐ Female ☐ Male
☐ Female-to-Male (FTM)/Transgender Male/Trans Man ☐ Choose not to disclose
☐ Male-to-Female (MTF)/Transgender Female/Trans Woman ☐ Additional gender category or other, please specify _____
☐ Genderqueer, neither exclusively male nor female

Sexual Orientation ☐ Bisexual ☐ Lesbian, gay or homosexual
☐ Choose not to disclose ☐ Something else, please describe: _____
☐ Don't Know ☐ Straight or heterosexual

Mailing Address	City	State	Zip Code

Employer Name	Work Phone Number	Occupation

In case of an emergency call:	Phone Number

Responsible Party
Information of Person Financially Responsible
(Parent if patient is under 18)
If different from above

Last Name	First Name	Middle Initial

Date of Birth	Social Security #	Phone Number	# of Dependents (family size) :____

Employer Name	Occupation

Insurance Information
Please provide the staff with your insurance card

Carrier's Name	Policy #	Group #	Relation to Patient

Carrier's Address	Subscriber

City	State	Zip Code	Telephone

FOR OFFICE USE ONLY:

Monthly Salary_____Do you work all year: ☐ yes ☐ no If No, Months not Worked:_____

How do you support your family when not working?_____

How was income information verified? ☐ Income Tax Statement ☐ Check Stubs (Previous 6 months)

Patient's Migrant Status: ☐ Migrant ☐ Seasonal ☐ NOT Farm Worker

Patient's Homeless Status: ☐ Not Homeless ☐ Doubling up ☐ Shelter ☐ Street ☐ Transitional ☐ Unknown/Unreported

Category: ☐ Private ☐ INS ☐ SOFP ☐ IM ☐ Medi-Cal ☐ EAPC ☐ BCCP ☐ H.F. ☐ MO ☐ MM ☐ CCA

For office use Only: ❒ Patient information updated on EPM including scanning of Insurance information
Date/ Initial this form when completed

Date Completed:_____Initials: _____

PEDIATRIC HEALTH HISTORY

Patient Name: _____ DOB: _____ Gender: _____

MEDICAL HISTORY

Yes No

1. Is the child currently under the care of a physician? ○ ○

Physician: _____ Office Phone: _____

Condition: _____

Yes No

2. Is the child taking any medication(s)? If yes, what medication(s)? ○ ○

_____

Yes No

3. Does the child smoke? ○ ○
4. Does the child drink alcohol? ○ ○
5. Does the child use any illicit drugs(amphetamine, cocaine,etc)? ○ ○
6. Is the child allergic to or has he/she reacted adversely to any of the following? ○ ○

☐ Local Anesthetics ☐ Penicillin ☐ Iodine ☐ Sulfa drugs ☐ Aspirin ☐ Codeine or other narcotics ☐ Latex/Rubber

☐ Other: _____

Yes No

7. Does the child have a prosthetic joints or metal inserts? ○ ○
8. Does the child have any history of Oral Cancer? ○ ○
9. Do you have or have you had any of the following? ○ ○

	Yes	No		Yes	No		Yes	No
A. Heart conditions	○	○	E. Seasonal Allergy	○	○	K. HIV/AIDS	○	○
B. High Blood Pressure	○	○	F. Fainting spells or seizures-Epilepsy	○	○	L. Stomach ulcers	○	○
1. Pain in chest upon exertion	○	○	G. Diabetes (Typel or II)	○	○	M. Kidney trouble	○	○
2. Cardiac pacemaker	○	○	H. Hepatitis, jaudice or liver disease	○	○	N. Tuberculosis	○	○
C. Sinus trouble	○	○	I. Anemia	○	○	O. ADHD-Attention Deficit Hyperactivity Disorder	○	○
D. Asthma	○	○	J. Arthritis	○	○	P. ADD-Attention Deficit Disorder	○	○

DENTAL HISTORY

Yes No

1. Has the child had abnormal bleeding associated with previous extractions, surgery, or trauma? ○ ○
2. Had the child had surgery or x-ray treatment for a tumor, growth, or other condition of your mouth or lips? ○ ○
3. Has the child had any serious trouble associated with any previous dental treatment? ○ ○
4. How many times do you brush your child's teeth each day? ○ Once ○ Twice ○ Three times

Yes No

5. Do you use dental floss on the child? ○ ○
6. Do the child's gums bleed or hurt? ○ ○
7. Are any of the child's teeth sensitive to: ☐ Hot ☐ Cold ☐ Sweet ☐ Pressure

Yes No

8. Does food get caught in your child's teeth? ○ ○
9. Does the child clench or grind his/her teeth? ○ ○
10. Has the child experienced any pain or soreness in the muscles of your face or around your ear? ○ ○
11. Does the child's jaw click or pop? ○ ○

ORAL HABITS

☐ Thumb sucking ☐ Mouth breathing ☐ Tongue thrusting ☐ Brushing/Grinding ☐ Lemon/Lime/Orange Sucking

To the best of my knowledge,all of the preceding answers are true and correct. If there is any change in my child's health or medications, I will, without fail, inform the doctor on his/her next appointment.

Parent/Guardian: Date:

Dentist: Date:

DDS COMMENTS: ASA ○ I ○ II ○ III ○ IV Medical Clearance Request ○ Yes ○ No

CSVS Form #2025

Patient Responsibilities

1. **Providing Information** - Patients and families, as appropriate, must provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalization, medications, and other matters relating to their health. Patients and their families must report perceived risks in their care and unexpected changes in their condition. They can help the organization understand their environment by providing feedback about service needs and expectations.

2. **Asking Questions** - Patients and families, as appropriate, must ask questions when they do not understand their care, treatment, and service or what they are expected to do.

3. **Following Instructions** - Patients and their families must follow the care, treatment and service plan developed. They should express any concerns about their ability to follow the proposed care plan or course of care, treatment, and services. The organization makes every effort to adapt the plan to the specific needs and limitations of the patients. When such adaptations to the care, treatment, and service plan are not recommended, patients and their families are informed of the consequences of the care, treatment, and service alternatives and not following the proposed course.

4. **Accepting Consequences** - Patients and their families are responsible for the outcomes if they do not follow the care, treatment, and service plan.

5. **Following Rules and Regulations** - Patients and their families must follow organization's rules and regulations.

6. **Showing Respect and Consideration** - Patients and their families must be considerate of the organization's staff and property, as well as other patients and their property.

7. **Meeting Financial Commitments** - Patients and their families should promptly meet any financial obligation agreed to with the organization.

I understand that Clinica de Salud has agreed to provide services that are available to members of my medical/dental/optometry plan. In the event that my membership cannot be verified, or is denied for any reason, I will be personally responsible for the value of the services received in accordance with CSVS fee schedule.

Patient Signature (Parent or Guardian)

Name (Please Print) **Date of Birth**

Date **Medical Record Number**