# SBCHC PATIENT INFORMATION FORM

Today's Date_____ Patient's Date of Birth_____
Gender of Patient (Circle): Male Female Other

PLEASE ANSWER EVERY QUESTION. THIS INFORMATION IS CONFIDENTIAL AND USED FOR STATISTICAL PURPOSES ONLY. THIS IS IMPORTANT FOR SBCHC TO RECEIVE GRANTS AND FUNDING FROM VARIOUS SOURCES TO HELP PROVIDE PATIENT SERVICES.

## I. PATIENT INFORMATION

LAST NAME: FIRST NAME: MIDDLE NAME:_____
ADDRESS: CITY: STATE: ZIP CODE:_____
SCHOOL ATTENDING:_____

## II. PARENT/GUARDIAN/SELF INFORMATION

PARENT/GUARDIAN LAST NAME: FIRST NAME:_____
CELL PHONE NUMBER: HOME: WORK:_____
EMAIL:_____
Relationship to Patient (please circle):Parent Guardian Grandparent Foster Parent Self
How do you like to be contacted (please circle): Email Cell Work Home Text

## III. EMERGENCY CONTACT

In the event of an emergency, whom shall we contact?
Name: Relationship:
Phone Number:_____

## IV. FINANCIAL INFORMATION

1. Do you have Medi-Cal? Please Circle: YES NO
2. Do you have any type of other Dental Insurance? Circle: YES NO
3. Who is responsible for payments on account?_____
4. What is the Source of your Income? Circle:

Job Cal Works/General Relief Disability Child Support
Savings Retirement Unemployment Other

5. If you are a parent/guardian answering for a minor, who does the patient live with: Circle:

Both Parents Mom Dad Foster Parent Grandparents Other_____

6. How did you hear about us? Please Circle One:

School: _____ Medi-Cal
Friend/Relative:_____ Internet
WIC:_____ Health Fair (which one?)_____
Beach Cities Health District Other:_____

# SBCHC CONFIDENTIAL HEALTH HISTORY

Patient Name: _____ Date of Birth: _____
Today's Date: _____

## I. Medical History

1. Physician's Name and Phone number: _____
2. Month/Year of last routine medical exam? _____
3. Patient is under the care of a physician now? Yes / No If Yes, why? _____
4. Patient is up to date with immunizations? Yes / No
5. **Patient is presently taking medications, including asthma? Yes/No** If yes, what and why?

_____

6. **Patient has allergies (medications, food, latex/rubber)? Yes/No** If yes, what? _____
7. Patient has been hospitalized? Yes/No If yes, why and when? _____
8. Patient has had any operations or General Anesthesia? Yes/No If yes, why and when? _____
9. If yes, were there any complications? Yes/No If yes, please explain _____
10. Was the baby full term at birth? Yes/No If no, how many weeks gestation was he/she? _____

## II. Has Patient Experienced, have or had any of the Following, this information will not be released unless specifically authorized by patient/guardian? (Please circle Yes or No for each)

| | | | |
|---|---|---|---|
| Yes/No | Diagnosed ADD/ADHD | Yes/No | HIV |
| Yes/No | Diagnosed Autism | Yes/No | Hypoglycemia |
| Yes/No | Diagnosed Anxiety or Depression | Yes/No | Jaundice |
| Yes/No | Asthma | Yes/No | Kidney Disease |
| Yes/No | Artificial Joints | Yes/No | Liver Disease or Hepatitis |
| Yes/No | Diagnosed Behavioral Issues | Yes/No | Mental Health Issues not anxiety/depression |
| Yes/No | Blood Disease/Transfusion | Yes/No | Diagnosed Neurological Disorders |
| Yes/No | Cancer | Yes/No | Pregnancy |
| Yes/No | Cold Sores | Yes/No | Radiation Treatment |
| Yes/No | Congenital Syndrome | Yes/No | Respiratory Problems |
| Yes/No | Developmental Delay including Speech | Yes/No | Rheumatism |
| Yes/No | Diabetes | Yes/No | Seasonal Allergies |
| Yes/No | Dizziness and Fainting | Yes/No | Sickle Cell Disease |
| Yes/No | Epilepsy/Seizures | Yes/No | Sinus Problems |
| Yes/No | Frequent Cough | Yes/No | Skin Disorders including Eczema |
| Yes/No | Gastro-Intestinal Problems | Yes/No | Smoking/History of Smoking or Vaping |
| Yes/No | Glaucoma | Yes/No | Thyroid Disease |
| Yes/No | Eye Disease | Yes/No | Tuberculosis |
| Yes/No | Hearing Loss | Yes/No | Tumors |
| Yes/No | Heart Disease/Murmur | Yes/No | Venereal Disease/STD |
| Yes/No | High Blood Pressure | Yes/No | Anything Not Listed |

**12. Does the patient have or has he/she had any other diseases or medical problems NOT listed on this form? Yes / No**
**13. If yes explain:**

_____

**14. Is there any other issue or condition that you would like to discuss with the dentist in private? Yes / No**

Patient Name: _____ Date of Birth: _____

## I. Dental Health History

1. Is this the patient's first visit at this office? Yes / No Please list the reason for the visit:

_____

2. Date of the last dental exam and dental x-rays:

_____

3. Is the patient scared of the dentist? Yes / No If yes explain why:

_____

4. What kind of water does the patient usually drink: tap water or bottled water: _____
5. Does the patient drink soda, juice, or any other sugary drinks on a regular basis? Yes / No
6. Does the patient snack often? Yes / No If yes, name some common foods that he/she snacks on?

_____

7. Do you as the parent/guardian have a dentist? Yes / No
8. Do you and/or the patient Vape? Yes/No
9. Do you and/or the patient use Marijuana? Yes/No

## II. Has the patient experienced, have or had any of the following? (Please circle Yes or No for each)

| | | | |
|---|---|---|---|
| Yes/No | Snore | Yes/No | Thumb or Finger Sucking or Pacifier? Until what age? |
| Yes/No | Mouth Breathing | Yes/No | Any habits such as tongue thrust, biting nails, etc… |
| Yes/No | Habit of going to bed with milk? Bottle/nursing | Yes/No | Speech Problems |
| Yes/No | Dental Decay in the past two years | Yes/No | Jaw Pain, clenching, grinding |

10. How often does the patient brush his/her teeth? _____
11. Does the patient floss his/her teeth? Yes / No If yes, how often? _____

**I certify that I have read and understand this form. I have reviewed the Medical Health History and confirm that it accurately states the past and present conditions. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my/patient's health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.**

**Signature of Patient (Parent or Guardian)** _____ **Date** _____ **Signature of Dentist** _____ **Date**

Patient Name: _____ Date of Birth: _____

Today's Date:_____

## V. STATISTICAL INFORMATION?

1. Are you (please circle) Single Divorced Married Separated Widowed

2. What is the patient's race/ethnicity?

**Circle all that apply:**

American-Indian/Alaskan Native
Asian
White/Caucasian
Hispanic/Latino-Black
Black/African America
Hispanic/Latino-White
Native Hawaiian or Pacific Islander
Mixed Race: _____

3. Primary Language Spoken at Home (Please circle):

English Spanish Cantonese
Mandarin Vietnamese Korean
Other

4. How many family members do you have in your household (don't include those that are not in your immediate family): _____

5. What is the estimated income you report on your taxes?_____

For patients that do not have medi-cal, we will require proof of income once a year to put you on the sliding scale fee schedule which is adjusted based on your income level.

Patient Name: _____ Date of Birth: _____
Today's Date: _____

**Patient authorizations:**

Initial _____I authorize the SBCHC dental team to perform any necessary dental services that the patient may need and that I or an authorized party has consented to during diagnosis and treatment. In addition, I authorize the taking of radiographs, and/or other diagnostics appropriate for a thorough evaluation. I authorize the use of local anesthetic as deemed necessary by the treating dentist.

Initial _____I have read the **office policies** and agree to the terms including all scheduling and financial terms.

Initial _____I authorize the release of information necessary to process my dental benefit claims.

**Patient Communications:**

Initial _____**Voice Messages:** I understand brief messages from the dental practice may be left on my home answering machine, my cell phone, my work phone if listed on my information sheet or with anyone who answers the telephone at my home unless I have provided the practice with alternate instructions for communication.

**Please initial only those that apply to you regarding Email:** Unencrypted email is not a secure form of communication. However, you may consent to receive unsecured email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication. Our first email to you will verify your email address.

*I accept the risk in receiving information via unencrypted email. I understand I can withdraw my consent at any time. I consent to receiving appointment reminders via unencrypted email. I understand the minimum necessary information is used in these reminders. I understand I can withdraw my consent at any time.*

Please Circle One: I do give consent I don't give consent

Initial _____Cell phone: I consent to the dental practice using my cellphone number to call or text regarding appointments and to call regarding treatment, insurance and my account. I understand that I can withdraw my consent at any time.

**Patient Acknowledgements:**

Initial _____I hereby acknowledge that a copy of this practice's **Notice of Privacy Practices** has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Initial _____I hereby acknowledge that a copy of this practice's **Dental Materials Fact Sheet** has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet.

# SBCHC DENTAL CLINIC OFFICE POLICY

Thank you for entrusting South Bay Children's Health Center with your family's dental care. SBCHC is a non-profit dental clinic using grants, fundraising and patient payments to provide high quality dental care at affordable rates. It is necessary that you agree to our office policies for us to provide the best service possible.

1. The office is open Monday through Wednesday 8AM-6PM and Thursday from 7AM-4:30PM. We see patients by appointment. In the case of an emergency, please call first thing in the morning and we will do our best to schedule you as soon as possible.

2. Income verification is required for patients who are not insured once per year (not necessary for Medi-cal).

3. Using photography or video during dental procedures is not allowed unless pre-approved by your provider.

4. Parents are able to come in back for new patients, patients that are 5 and under who need a parent and kids who are uncooperative. All other parents/guardians will be asked to wait in the waiting area until necessary. From our experience, most treatment visits are more successful when a child is able to build a relationship of trust with the doctor and staff and doctors can focus on the child's treatment and behavior management. Parents will be called in back when necessary and be given updates at any time.

5. Young children should be seen in the morning because they tend to be more cooperative. Dental appointments are considered an excused absence from school by law and we will be happy to provide the necessary paperwork.

6. We require 24-hour advance notice for a cancellation. Cancellations within less than 24 hours will be subject to a $20 charge. After two failed appointments we may ask you to seek dental care at another office that may better accommodate your schedule.

7. Please be on time for your appointments. If you are late by more than 10 minutes it is at our discretion to reschedule your appointment and you may incur a $20 failed appointment charge.

8. Please provide accurate insurance information prior to treatment. If insurance coverage is not verified, we have a right to charge you for provided services.

9. Please notify us immediately if your child is sick and we are happy to reschedule you. If we are concerned with your child's health at the time of the appointment, we have the right to reschedule.

10. Payment is expected at time of service.

11. SBCHC accepts the following methods of payment: cash and all major credit cards.

12. Patients under the age of 18 must have a parent/guardian present during their 1st visit. Once treatment has been consented, follow-up work may be done with an authorized adult. Children under 12 must have an adult waiting until the appointment is completed.

13. We are a non-profit dental clinic that works with institutions to educate providers in training. We often utilize licensed volunteers, externs, residents and dental/dental hygiene students. Although we try to keep patients with the same provider, this is not always possible.

14. EFFECTIVE MAY 2020: To lower the risk of Covid transmission for our patients (many who are too young to be vaccinated) and our staff, we have closed our indoor waiting area until further notice. Please feel free to wait outside the front of the office (chairs can be provided) or in your car. We are also requiring masks for all children and adults over the age of 2 in our office.

Parent/Guardian Signature:_____