The notice of Privacy Practices tells you how Caring Hands Dental Clinic may use or disclose information about you. Not all situations will be described. Caring Hands Dental Clinic will provide to you, upon request, a copy of our Privacy Practices to keep or you can examine the framed pages located in our waiting room. Caring Hands Dental Clinic is required to share this information with you regarding our Privacy Practices and the information we collect and keep about you. Please review it carefully.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

* You may refuse to sign this acknowledgement •

I, (patient or decision maker's name)_____, have reviewed or been given a copy of the Caring Hands Dental Clinic's Notice of Privacy Practices. I have had the opportunity to ask questions about how my information may be used.

We ask that you, the patient, or your parent, guardian or substitute decision maker sign this form. You do not have to sign. We use this form, which is required by the Government, to show that you have received Notice of the Privacy Practice. The information of this form applies to all current and future contacts while you are here or after you leave. It applies to contacts which are in person, on the phone, via fax, email or by mail.

Patient signature_____Date_____

Parent / Guardian signature_____Date_____

Caring Hands Dental Clinic attempted to obtain written acknowledgement of Receipt of Notice of Privacy Practices, but signature could not be obtained because:

_____ Patient or decision maker refused to sign

_____ Patient or decision maker unable to sign

Staff signature_____Date_____

If this information is needed in a different form, please ask us for assistance.

Please complete both sides. Over...

APPOINTMENT POLICY
CARING HANDS DENTAL CLINIC

If for any reason you are unable to keep an appointment, you must call at least 24 hours prior to the appointment or it will be considered a failed appointment.

Anyone arriving more than 15 minutes late may have to attempt to reschedule, as your appointment may be given to someone waiting.

It is very important that the appointment you scheduled with our clinic is kept and you come on time. With the huge demand we have for our services, it is necessary to have a policy in place regarding scheduled appointments.

Failure to keep an appointment or to come late may result in future dental problems due to lack of treatment. As well as denying someone else of receiving care.

For people 16 and older, one failed appointment puts you at the back of the waiting list, 2 failed appointments for 16 and older requires you to find a different dental provider or possibly be required to pay for the cost of **empty chair time which currently runs $160.00 per hour,** should you desire to continue being seen here. **Uninsured patients** will be asked to go elsewhere on first failed appointment and/or pay for empty chair time.

For children 15 and younger, one failed appointment, we keep you on the current list, second failed appointment, you go to the back of the list and three failed appointments we ask that you find a different dental provider or possibly be required to pay for the cost of **empty chair time which currently runs $160.00 per hour,** should you desire to continue being seen here.

The Staff and Volunteers at Caring Hands look forward to providing your dental needs, but due to the tremendous demand, we must adhere to the above policies for the benefit of all involved. We also understand weather, family and sickness and will try to be as fair as possible, but repeated cancellations can jeopardize your use of our services.

In 2018, the Clinic lost $275,450.00 from failed appointments – creating empty chair time.

Please sign below that you have read and understand our appointment policy.

_____

Please print your name

_____

Please Sign and Date

Please complete both sides. Over...

CARING HANDS DENTAL CLINIC

PATIENT IDENTIFICATION FORM

Patient Name: _____ Patient Birth Date: _____

Address: _____ Phone No.: ( )_____

City, State, Zip: _____ Alternate Phone No.: ( ) _____

Email Address: _____ Today's Date: _____

County of Residence:_____ Group Home:_____

Employer: _____ Employer Phone No.: ( ) _____

Marital Status: Single Married (circle one) Male Female (circle 0ne)

Language Used: English Spanish Other:_____

Ethnic Background: Optional (circle one) Hispanic African American American Indian Asian White

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If there is a legal guardian, please fill in the information below:

Parent's Name: _____ Phone No.: ( )_____

Parent's Address: _____ Work No.: ( )_____

_____

Guardian's Name:_____ Phone No.: ( )_____

Guardian's Address: _____ Work No.: ( )_____

Please fill out this section completely, including telephone numbers

Physician: _____ Phone No.: ( )_____

Address: _____

Previous Dentist:_____ Phone No.: ( )_____

Address: _____

Pharmacy Used: _____ Phone No.: ( )_____

Medical Insurance

ID#_____ _____ _____ _____ _____ _____ _____ _____

"I authorize the release of my medical information to my insurance carrier as necessary to process any claims. I authorize payment of medical benefits to Caring Hands Dental Clinic for services rendered." I also authorize release of my dental and medical information to:

_____

Patient / Guardian Name: (Please Print)_____

Patient / Guardian Signature:_____Date:_____

MEDICAL HISTORY

Patient Name_____Today's Date_____Date of Birth:_____

1. Other than routine visits, have you been under the care of a medical doctor during the past two years? Yes No

   If yes, for what?_____

   Physician's Name_____Phone_____

   Address_____City_____State_____Zip_____

2. Have you taken any medication or drugs during the past two years? . . . . . Yes No

3. Are you taking any medication, drugs or pills now? . . . . . Yes No

   If yes, please list name and dosage_____

4. Have you had a bad reaction to any of the following:

   Aspirin Codiene Nitrous Oxide Tetracycline Valium Clindamycin Novocaine Anesthetic

   Ibuprofen Demerol Erythromycin Percodan Penicillin Sulfa Sleeping Pills

   Any others not listed? Yes No _____

5. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (surgery, disease, attack)	Yes No	Ulcers.	Yes No	Hepatitis A (infectious) B (serum) . .	Yes No
Chest Pain	Yes No	Latex Sensitivity	Yes No	Venereal Disease.	Yes No
Congenital Heart Disease.	Yes No	Diabetes.	Yes No	AIDS	Yes No
Heart Murmur	Yes No	Thyroid Problems	Yes No	HIV Positive	Yes No
High Blood Pressure.	Yes No	Glaucoma	Yes No	Cold Sores/Fever Blisters.	Yes No
Mitral Valve Prolapse	Yes No	Contact Lenses	Yes No	Blood Transfusion.	Yes No
Artificial Heart Valve.	Yes No	Emphysema	Yes No	Hemophilia	Yes No
Heart Pacemaker.	Yes No	Chronic Cough	Yes No	Sickle Cell Disease	Yes No
Rheumatic Fever.	Yes No	Tuberculosis	Yes No	Bruise Easily	Yes No
Arthritis/Rheumatism	Yes No	Asthma	Yes No	Liver Disease.	Yes No
Cortisone Medicine.	Yes No	Hay Fever.	Yes No	Yellow Jaundice	Yes No
Swollen Ankles	Yes No	Allergies or Hives	Yes No	Neurological Disorders	Yes No
Stroke.	Yes No	Sinus Trouble	Yes No	Epilepsy or Seizures	Yes No
Diet (special/restricted)	Yes No	Radiation Therapy	Yes No	Fainting or Dizzy Spells	Yes No
Artificial Joints (hip, knee, etc.) . . .	Yes No	Chemotherapy	Yes No	Nervous/Anxious	Yes No
Kidney Trouble	Yes No	Tumors.	Yes No	Psychiatric/Psychological Care . .	Yes No

6. Do you take blood thinner or aspirin daily? . . . . . Yes No

7. Have you lost or gained more than 10 pounds in the past year? . . . . . Yes No

8. Do you have or have you had any disease, condition or problem not listed? . . . . . Yes No

   If yes, Please list_____

9. Women: Are you: Pregnant? Yes _____Months No Nursing? Yes No Taking birth control pills? Yes No

List Allergies to Medications:_____

List Allergies to Food or Other:_____

Smoker: Yes No

Smokeless Tobacco: Yes No

Signature:_____ Date:_____

Please complete both sides. Over...

DENTAL HISTORY

Patient Name_____Date of Birth:_____

What is the reason for your visit today?_____

Do you have any dental problems now? Yes No

If yes, please describe:_____

Date of Last Dental Exam_____**Last Dental Cleaning**_____**Last X-rays**_____

What was done at your last visit?_____

Why have you chosen our office for your dental care?_____

Referred by?_____

Previous dentist's name_____

Address_____City_____State_____Zip_____

Have you made regular dental visits? Yes No How often?_____

How often do you brush?_____ Floss?_____

What other dental aids do you use? (Water Pik, Interplak, Toothpick, etc.)_____

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters, or any oral lesions?	Yes	No

Do your gums bleed or hurt?

Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite	Yes	No
Does food tend to become caught between your teeth?	Yes	No

If yes, where?_____

Have you lost any teeth or had teeth removed? Yes No

Why_____

Have they been replaced? Yes No

How? Fixed bridge Partial Denture Implant

Are you happy with replacement? Yes No

If no, why_____

_____

_____

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breath while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/Chew tobacco?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause_____

_____

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches, or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

Are you satisfied with your teeth's appearance? Yes No

Would you like to keep all of your teeth all of your life? Yes No

Do you feel nervous about having dental treatment? Yes No

If so, what is your biggest concern?_____

_____

Have you ever had an upsetting dental experience? Yes No

If yes, please describe_____

_____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe_____

_____

_____

_____

_____

Please complete both sides. Over...