(Office Use Only) MR#:______________

SYCUAN MEDICAL DENTAL CENTER

Patient Demographic Form

Name ____
Last First M.I.

Patient S.S. #: ______ - ______ - ______ Sex: ☐ Male ☐ Female

Date of Birth: ______ /_______ /______ Email Address: ______________________

Residence Address: ________________________________ Apt# _________

City: ____________________ State: _______________ Zip Code: _____________

Mailing Address: ________________________________ Apt# _________
(If different than Residence Address)

City: ____________________ State: _______________ Zip Code: _____________

Home Phone: ______________________ Cell Phone: _________________________

Work Phone: __________________ X: ________ Department: __________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Emergency Contact: ____

Relationship to Patient: ____________________Telephone # ______________________

Emergency Contact's Address: ____

If patient is a minor, please indicate Parent's/Guardian's information if different than Patient's Information.

Father's Name: _________________________ Telephone # ______________________

Father's Address: ____

Mother's Name: _________________________ Telephone # ______________________

Mother's Address: ____

Primary Insurance Co: _______________ ID# ______________ Grp# ______________

Secondary Insurance Co: _____________ ID# ______________ Grp# ______________

Policy Holder's Name: __________________________ ID# ______________________

Policy Holder's DOB: _____ / ______ / ______ Policy Holder's SS# _____ / _______ / _______

Policy Holder's Address: ____________________________________ Copay Amount $____

Please list the name(s) of a person(s) with whom we can share the patient's Protected Health Information, and who can pick up prescriptions, in the event you are unable to:
(If none, then write "None")

____

____

I hereby authorize and request the performance necessary for treatment using whatever procedures the judgement of the provider may dictate during my treatment.

Patient Signature: ___________________________________ Date: _________________

Parent/Guardian Signature: ____________________________ Date: _________________

Revised June 12, 2018

SYCUAN MEDICAL DENTAL CENTER

General Consent for Dental Diagnosis and Treatment & Notice of Privacy Practices and Non-Discrimination Acknowledgment of Receipt

Consent for Treatment

The undersigned patient or responsible guardian of a minor patient consents to authorize our dentists or dental assistants who are under the general supervision of our dentists, to perform an examination and other diagnostic procedures deemed necessary to render proper dental care. By signing below the patient or responsible guardian of a minor patient acknowledge that the above statements have been read and that the consent for treatment and to receive medication from our healthcare providers is given.

____ ____________________
Print Name of Patient of Personal Representative Date

____
Signature of Patient (Or Patient's Parent/Conservator/Guardian/Personal Representative)

Notice of Privacy Practices and Non-Discrimination Acknowledgment of Receipt

By signing this form, you acknowledge your right to request to review the *HIPAA Notice of Privacy Practices and Non-Discrimination* of *Sycuan Medical Dental Center*. Our *HIPAA Notice of Privacy Practices and Non-Discrimination* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our *HIPAA Notice of Privacy Practices and Non-Discrimination* is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our organization at: 619-445-0707. If you have any questions about our *HIPAA Notice of Privacy Practice*s *and Non Discrimination*, please contact: The Privacy Officer: 5442 Sycuan Road, El Cajon, CA 92019, (619) 445-0707 x172, or bsandoval@sycuanmed.org.

I acknowledge my right to review the HIPAA *Notice of Privacy Practices and Non-Discrimination* of Sycuan Medical Dental Center.

____ ____________________
Signature of Patient (Or Patient's Parent/Conservator/Guardian/Personal Representative) Date

SYCUAN MEDICAL DENTAL CENTER

Health History Form

Name: ______________________________ Date: ____________
Last First M.I.

Home Phone: ____________ Business/Cell Phone: ____________ E-mail: ______________

Address: ______________________________
Street City State Zip code

Date of Birth: ____________ Height: __________ Weight: __________ Sex: M F

Social Security #: ________________ Occupation: ____________________

Emergency Contact: ____________ Relationship: __________ Contact's Phone #: __________

If you are completing this form for another person, what is your relationship to them? ____________

Please list all medications you are currently taking:

Medication Name	Strength	Frequency

Do you have any of the following diseases or problems?

	Yes	No
Active Tuberculosis	☐	☐
Persistent cough greater than a 3 week duration	☐	☐
Cough that produces blood	☐	☐
Been exposed to anyone with tuberculosis	☐	☐

Dental Information *(for the following information, please mark (X) your responses to the following questions)*

	Yes	No
Do your gums bleed when you brush or floss?	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐
Does food or floss catch between your teeth?	☐	☐
Is your mouth dry?	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐
Is your home water supply fluoridated?	☐	☐
Do you drink bottled or filtered water?	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY		
Are you currently experiencing dental pain or discomfort?	☐	☐

	Yes	No
Do you have earaches or neck pain?	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐
Do you brux or grind your teeth?	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐
Do you wear dentures or partials?	☐	☐
Do you participate in active recreational activities?	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐

Date of your last dental exam: ____________

What was done at that time? ____________

Date of last dental x-rays? ____________

What is the reason for your dental visit today? ____________

How do you feel about your smile? ____________

Medical Information *(Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems)*

	Yes	No
Are you now under the care of a physician?	☐	☐

Physician Name: ____________

Phone: ____________

Address: ____________

	Yes	No
Are you in good health?	☐	☐
Has there been any change in your general health within the past year?	☐	☐

If yes, what condition is being treated? ____________

Date of last physical exam? ____________

	Yes	No
Do you wear contact lenses?	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐

Date: ________ If yes, have you had any complications? ________

	Yes	No
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐

If yes, what was the illness or problem? ____________

	Yes	No
Are you taking or have recently taken any prescription Or over the counter medicine(s)?	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: ____________

	Yes	No
Do you use controlled substances (drugs)?	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐

If so, how interested are you in stopping?
Circle one) VERY / SOMEWHAT / NOT INTERESTED

Medical Information *(Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems)*

Question	Yes No
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedrinate (Actonel®) for osteoporosis or Paget's disease? …………………………………..	☐☐
Do you drink alcoholic beverages?..	☐☐
If yes, how much alcohol did you drink in the last 24 hours? _________	
If yes, how much do you typically drink in a week? ________________	

Question	Yes No
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal Complications resulting from Paget's disease, multiple myeloma Or metastatic cancer? ……………………………………………….	☐☐
Date treatment began? ______________	
Women Only Are you:	
Pregnant? ………………………………………………..………..	☐☐
Number of Weeks: ____________	
Taking birth control pills or hormonal replacement? ….………..	☐☐
Nursing? ……………………………………………….…………	☐☐

Allergies – Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

Allergy	Yes No
Local anesthetics ____	☐☐
Aspirin ____	☐☐
Penicillin or other antibiotics _________________________________	☐☐
Barbiturates, sedatives, or sleeping pills ______________________	☐☐
Sulfa drugs ____	☐☐
Codeine or other narcotics __________________________________	☐☐
Metals ____	☐☐
Latex (rubber) ______________________________________	☐☐
Iodine ____	☐☐
Hay Fever/seasonal _________________________________	☐☐
Animals ____	☐☐
Food ____	☐☐
Other ____	☐☐

(Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems)

Condition	Yes No
Artifical (prosthetic) heart valve ………………………………………	☐☐
Previous infective endocarditis ………………………………………..	☐☐
Damaged valves in transplanted heart ………………………………...	☐☐
Congential heart disease (CHD)	
Unrepaired, cyanotic CHD ………………………………………..	☐☐
Repaired (completely) in the last 6 months ………………….……	☐☐
Repaired CHD with residual defects ……………………………...	☐☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended For any other form of CHD.

Condition	Yes No
Cardiovascular disease……..	☐☐
Angina…………………….….	☐☐
Arteriosclerosis……………	☐☐
Congestive heart failure…..	☐☐
Damaged heart valves ……..	☐☐
Heart attack ……………….…	☐☐
Heart murmur……………...	☐☐
Low blood pressure ……..…	☐☐
High blood pressure …….....	☐☐
Other congenital heart defects ……….……...	☐☐
Stroke ……………...………	☐☐
Mitral valve prolapse……….….	☐☐
Pacemaker……………..…….....	☐☐
Rheumatic fever……….….…...	☐☐
Rheumatic heart disease…….....	☐☐
Abnormal bleeding ………..….	☐☐
Anemia ……………………..…	☐☐
Blood transfusion ………..….…	☐☐
If yes, date: _______________	
Hemophillia …………………...	☐☐
AIDS or HIV infection ……….	☐☐
Arthritis ………………………..	☐☐
Glaucoma ……………………...	☐☐
Autoimmune disease ……….	☐☐
Rheumatoid arthritis …........	☐☐
Systemic lupis erythematosus.	☐☐
Asthma ………………...……	☐☐
Bronchitis ……….…..….….	☐☐
Emphysema ………………..	☐☐
Sinus Trouble ………………	☐☐
Tuberculosis ……………..…	☐☐
Cancer/Chemotherapy/ Radiation treatment…………	☐☐
Chest pain upon exertion……	☐☐
Chronic pain………………..	☐☐
Diabetes Type I or II ……….	☐☐
Eating disorder ……………...	☐☐
Malnutrition ………………...	☐☐
Gastrointestinal disease ……	☐☐
G.E. Reflux/persistent heartburn …………………...	☐☐
Ulcers ……………………..…	☐☐
Thyroid problems …………..	☐☐
Excessive urination ……..…..	☐☐
Hepatitis, jaundice or Liver disease …………..	☐☐
Epilepsy ………………	☐☐
Fainting spells or Seizures ……………….	☐☐
Neurological disorders...	☐☐
If yes, specify: ____________	
Sleep disorder………...	☐☐
Mental health disorders	☐☐
Specify: _________________	
Recurrent infections…...	☐☐
Type of infection: __________	
Kidney problems ……...	☐☐
Night sweats ………..…	☐☐
Osteoporosis ……….....	☐☐
Persistent swollen glands in neck……….....	☐☐
Severe headaches/ migraines ……………....	☐☐
Severe or rapid weight loss ………….....	☐☐
S.T.D.'s ……..………...	☐☐

Question	Yes No
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ………………………………………....	☐☐

Name of physician or dentist making recommendation: ____ Phone: _________________________

Question	Yes No
Do you have any disease, condition, or problem not listed above that you think we should know about? …………………………………………...	☐☐

Please explain: ____

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior treatment.
I certify that I have read and understand the above information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

____

Signature of Patient/Legal Guardian Date

FOR COMPLETION BY DENTIST

Comments: ____
____
____
____

(Office Use Only) MR#:_______________

SYCUAN MEDICAL DENTAL CENTER

Patient Financial Form

Patient Legal Name ____ Register Date: ____ /____ /____
Last First M.I.

Patient S.S. #: ____ - ____ - ____ Date of Birth: ____ /____ /____ Spouse's Name: _____________________

Race/Ethnicity
___ American Indian/Alaskan Native
___ Asian/Pacific Islander
___ African American
___ Hispanic
___ White (Non-Hispanic)
___ Mixed/Other

If American Indian/Alaskan Native:
Tribe: ______________________________
Tribal Enrollment # ___________________
Tribal Blood Quantum _________________
Total AI/AN Blood Quantum ___________

Occupation: __________________________________ Name of Employer: ________________________________

U.S. Veteran _____ Yes _____ No Service Branch: ____

Person Responsible for Payment: __________________________________ Relationship: ____________________

Address: ____
Street City State Zip Phone #

(If applying for sliding scale)
Number of Persons in Household: __________ Annual Household Income: $_____________

	Primary Medical Insurance	Secondary Medical Insurance
Subscriber:	___________________________	________________________________
Relationship to Patient:	___________________________	________________________________
Subscriber's Social Security #:	___________________________	________________________________
Subscriber's Date of Birth:	___________________________	________________________________
Subscriber's Employer:	___________________________	________________________________
Subscribers Insurance Carrier:	___________________________	________________________________
Subscriber's Carriers Phone #:	___________________________	________________________________
Subscriber's Policy/Group #:	___________________________	________________________________

Certification Statement: I certify that the information above is true and accurate to the best of my knowledge. I hereby assign all medical benefits to include major healthcare benefits to which I am entitled, including MediCal, Medicare, private insurance and any other health insurance plan to Sycuan Medical Dental Center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

_______________________________________ _________________________
Name of Patient (Print) Date

_______________________________________ _____________________________ _________________________
Name of Responsible Party (Print) Relationship to Patient Driver's License #

____
Signature of Responsible Party

SYCUAN MEDICAL DENTAL CENTER

Screening for Aerosol Transmissible Diseases (ATD)

In compliance with Sycuan Medical Dental Center (SMDC) policy, dental procedures are not performed at the SMDC on patients suspected or identified as having aerosol transmissible diseases.

Circle all that apply:

Do you have a history of tuberculosis or symptoms of tuberculosis? **Yes** **No**

Productive Cough — Malaise
Bloody sputum — Night sweats
Fever — Unexplained weight loss

Do you have any of the following aerosol transmissible diseases? **Yes** **No**

Influenza (flu) — Chicken Pox
Pertussis — Meningitis
Measles — Rubella
Mumps

Do you have symptoms of any aerosol transmissible diseases? **Yes** **No**

Body aches — Fever
Runny Nose — Difficulty breathing
Nausea — Coughing spasms
Vomiting — Painful swollen glands
Diarrhea — Skin rashes or blistering

Do you have any of the following chronic respiratory diseases? **Yes** **No**

Bronchitis — Emphysema
Allergies — Asthma
Chronic upper airway cough syndrome-post nasal drip
Chronic obstructive pulmonary disease (COPD)
Gastroesophageal reflux disease (GERD)

Chronic respiratory diseases are NOT aerosol transmissible diseases and do not disqualify a patient from receiving dental treatment.

____ ______________________

Patient's Name (Print) — Date

____

Patient's Signature