SANTA YNEZ TRIBAL HEALTH CLINIC

PATIENT INFORMATION ☐ New ☐ Annual **CHART #:** _____

Last Name: _____ First Name: _____ MI: _____ Date of Birth: _____

Gender: ☐ M ☐ F SSN#: _____ ☐ Married ☐ Single ☐ Child ☐ Other: _____

Mailing Address: _____ City: _____ Zip: _____

Phone: H _____ W _____ C _____ **Email:** _____

ETHNICITY AND HOUSEHOLD INFORMATION

RACE: ☐ Santa Ynez Chumash ☐ Other Native American / Alaskan Indian: _____

☐ Other Chumash: _____ ☐ Other (non-Native): _____

Tribal Affiliation/Name: _____ Blood Quantum: ☐ ½ ☐ ¼ ☐ Other: _____

Father's Last Name: _____ DOB: _____ Place of Birth: _____ Tribe: _____

Mother's Maiden Name: _____ DOB: _____ Place of Birth: _____ Tribe: _____

Monthly Gross Income: $ _____ Total Family Size: _____

EMPLOYMENT INFORMATION

The following is for: ☐ the Patient ☐ the Patient's spouse ☐ other person responsible for payment

Employer Name: _____ Occupation: _____ Employer Phone: _____

Employer Address: _____ City: _____ Zip: _____

EMERGENCY CONTACT INFORMATION

Last Name: _____ First Name: _____ Relationship to Patient: _____

Address: _____ City: _____ Zip: _____

Phone: H _____ W _____ C _____ Best time to call: ☐ 8a-12p ☐ 12p-5p

FINANCIAL AND INSURANCE INFORMATION

SPOUSE OR RESPONSIBLE PARTY INFORMATION:

The following is for: ☐ the Patient ☐ the Patient's spouse ☐ other person responsible for payment

Last Name: _____ First Name: _____ MI: _____

DOB: _____ SSN#: _____

Address: _____ City: _____ Zip: _____

Phone: H _____ W _____ C _____ Best time to call: ☐ 8a-12p ☐ 12p-5p

INSURANCE INFORMATION:

Primary Insurance Plan: _____ ID#: _____ Group#: _____

Last Name of Insured: _____ First Name: _____ MI: _____ Date of Birth: _____

Patient's relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Secondary Insurance Plan: _____ ID#: _____ Group#: _____

Last Name of Insured: _____ First Name: _____ MI: _____ Date of Birth: _____

Patient's relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

CONSENT FOR SERVICES

- As a condition of your treatment at the Santa Ynez Tribal Health Clinic, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred on their care, and financial responsibility on the part of each patient must be determined before treatment.
- Patients who carry private insurance understand that all services furnished are charged directly to the patient and that he/she is personally responsible for payment of all services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.
- A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.
- In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.
- I grant my permission to you or your assignee, to telephone me at my home or at my work to discuss matters related to this form.

STAFF USE ONLY:

Place stamp here:

I HAVE READ THE ABOVE CONDITIONS OF TREATMENT AND PAYMENT, AND BY SIGNING BELOW, AGREE TO THEIR CONTENT.

Signature: _____ Date: _____

Guarantor of payment/responsible party:

Signature: _____ Date: _____

Relationship to Patient: ☐ Patient ☐ Parent/Guardian ☐ Other:

STAFF USE ONLY:

☐ Address verified by Eligibility Specialist Signature: _____

☐ CHS or Direct Status verified Signature: _____

DENTAL PATIENT MEDICAL HISTORY
Santa Ynez Tribal Health Clinic

Please answer all of the following questions. If you are unsure how to answer any question(s), please ask the front office staff for assistance.

Chart #: _____

Are you a registered patient at this Clinic? ☐ Yes ☐ No
What is the reason for your visit to the Dental Clinic? _____
What is the name of your medical doctor? _____
What is the date of your last physical examination? _____
Have there been any changes in your general health this past year? ☐ Yes ☐ No
List any medication (pills or drugs) your are currently taking: _____

PLEASE CHECK:	Yes	No	PLEASE CHECK:	Yes	No
1. Do you have a toothache now?	☐	☐	7. Do you have chest pains?	☐	☐
2. Have you received medical care in the past two years?	☐	☐	8. Do you use alcohol or other drugs?	☐	☐
3. Have you ever been hospitalized?	☐	☐	9. Do you use tobacco products?	☐	☐
4. Are you taking calcium replacement drugs (ie: Fosamax, Actonel, etc.)?	☐	☐	If yes, do you want to quit?	☐	☐
5. Are you allergic to or made sick by any medicine such as Penicillin, aspirin, or codeine?	☐	☐	10. Do you have reason to believe you have been exposed to AIDS or HIV?	☐	☐
6. Have you ever had a bleeding problem that needed medical treatment?	☐	☐	11. Does anyone in your family have diabetes?	☐	☐

Do you currently have, or have you ever had, any of the following?

1. Hepatitis	☐	☐	12. Asthma	☐	☐
2. Heart murmur	☐	☐	13. Sinus trouble	☐	☐
3. Heart Attack	☐	☐	14. Cancer or tumors	☐	☐
4. High Blood pressure	☐	☐	15. Epilepsy or seizures	☐	☐
5. Rheumatic Fever	☐	☐	16. Arthritis/rheumatism	☐	☐
6. Heart valve or pacemaker	☐	☐	17. Blood transfusions	☐	☐
7. Artificial Joint	☐	☐	18. Sexually transmitted disease	☐	☐
8. Anemia	☐	☐	19. Kidney problems	☐	☐
9. Stroke	☐	☐	20. Liver problems	☐	☐
10. Ulcers	☐	☐	21. Nervous or mental disorders	☐	☐
11. TB or lung disease	☐	☐	22. Diabetes	☐	☐

FEMALE PATIENTS ONLY:

Are you currently:	Yes	No
1. Pregnant?	☐	☐
2. Taking birth control pills?	☐	☐
3. Nursing?	☐	☐

ALL PATIENTS:

Do you have any disease, conditions, or problems not listed? ☐ ☐
If yes, please specify: _____
Do you have any concerns about receiving dental treatment? ☐ ☐
If yes, please specify: _____

STAFF USE ONLY

Place stamp here

The answers I have given are true to the best of my knowledge. I am indicating my consent for routine dental procedures such as x-rays, cleaning, fillings, crowns, and local anesthesia by signing below.

SIGNATURES

Patient: _____ Date: _____

Provider: _____ Date: _____

GENERAL DENTISTRY INFORMED CONSENT FOR PROCEDURES

NOTE: SOME PROCEDURES MAY NOT BE AVAILABLE AT THE SANTA YENZ TRIBAL HEALTH CLINIC

1. **Drugs and Medications**
   Antibiotics, analgesics, and other medications may cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

2. **Changes in Treatment Plan**
   During treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not evident during examination; the most common being root canal therapy following routine restorative procedures.

3. **Removal of Teeth**
   There are (sometimes) alternatives to removal of teeth, which the dentist will explain to you. Removing teeth does not always remove all of the infection, and it may be necessary to have further treatment. There are risks involved in having teeth removed, including pain, swelling, spread of infection, dry socket, loss of feeling in teeth, lips, tongue and surrounding tissue (parasthesia) that can last for an indefinite period of time (days or months), or fractured jaw. Further treatment by a specialist or hospitalization, if complications arise during or following treatment, is the patient's responsibility.

4. **Crowns, Bridges, and Caps**
   Sometimes, it is not possible to match the color of natural teeth exactly with artificial teeth. Temporary crowns may be applied, which may come off easily, and it is the patient's responsibility to be (be careful to) ensure that they are kept on until the permanent crowns are delivered. The final opportunity to make changes in a new crown, bridge, or cap (including shape, fit, size, and color) will be before final cementation.

5. **Dentures – Complete or Partial**
   Full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems associated with wearing these appliances are looseness, soreness, and possible breakage. The final opportunity to make changes in a new denture (including shape, fit, size, and color) will bed the "teeth in wax" try-in visit. Most dentures require relining approximately three (3) to twelve (12) months after initial placement. The cost for this procedure is not included in the initial denture fee.

6. **Endodontic Treatment (Root Canal)**
   There is no guarantee that root canal treatment will save a tooth, and complications can occur from the treatment. Occasionally, metal objects are cemented in the tooth or extended through the root, which does not necessarily affect the success of the treatment. Occasionally, additional surgical procedures may be necessary following root canal treatment (apicoectomy).

7. **Periodontal Loss (Tissue & Bone)**
   Periodontal problems cause gum and bone inflammation or loss, which can lead to the loss of teeth. Alternative treatment plans are gum surgery, replacements, and/or extractions. Undertaking any dental procedures may have a future adverse effect on periodontal conditions.

8. **Fillings**
   Care must be exercised in chewing on fillings, especially in the first twenty-four (24) hours, to avoid breakage. A more extensive filling than originally diagnosed may be required due to additional decay. Significant sensitivity is a common after-effect of a newly placed filling.

CONSENT FOR TREATMENT

Your signature below authorizes the dentist and/or hygienist of the Santa Ynez Tribal Health Clinic, to administer any treatment, or to administer such anesthetics, analgesics, and/or sedatives, and to perform such operations, as may be deemed necessary or advisable in your diagnosis and treatment. You acknowledge that you have been informed of all possible complications of the procedures, anesthetics, and/or drugs.

Patient Name (please print)	Patient Signature	Date

Parent/Guardian Signature	Date

Dentist/Hygienist Signature	Date

Santa Ynez Tribal Health Clinic

90 Via Juana Lane • PO Box 539 • Santa Ynez, Ca. 93460
P: (805)688-7070 •F: (805)686-2060
E: info@sythc.org • W: www.sythc.org

Acknowledgment of Privacy Practices, Assignment of Benefits & Health Care Directives

I understand that the information provided by me and stored in my health record is necessary for the Santa Ynez Tribal Health Clinic (SYTHC) and staff, in conjunction with Indian Health Services (IHS), to provide services for my health and well-being. I understand that my health record information is securely stored either electronically or physically, and that my health record or any portion of my health record shall not be disclosed to another agency or person(s), unless specified as routine use, without my signed consent.

I, _____, acknowledge the following:
(Print patient name or parent/legal guardian name here)

☐ I have been provided the *HIPAA Privacy Act Notice* to read.
☐ I have been provided the *Patient Rights and Responsibilities Notice* to read.

I may request a copy of either form from the receptionist if I so chose.

The Santa Ynez Tribal Health Clinic (SYTHC) is considered a training facility, and has, from time to time, non-employed staff (students, interns, interested physicians, health care representatives, surveyors, etc.) on our premises. Normally, these non-employed staff are allowed in patient care areas for observation and/or to assist a provider.

☐ I understand that I have the option, at any time, to request that non-employed staff (students, interns and/or other professionals) be excused while I am receiving direct patient care services.

_____ (Initial Here)

Assignment of Benefits:

I request that payment under my medical insurance be made directly to the Santa Ynez Tribal Health Clinic. I understand that I am financially responsible when:

- My Insurance carrier does not cover a specific service;
- My insurance does not pay for services(deductible); and/or
- My insurance has been terminated.

_____ (Initial Here)

Health Care Proxy/Advanced Health Care Directive:

If, at anytime, I should become temporarily or permanently unable to make healthcare decisions, my healthcare proxy shall be: _____.
(Print name here)

My healthcare proxy may make all decisions about:

- My Medical, Dental, and/or Behavioral (Mental) Health Care.

Such decisions shall be consistent with my wishes, or, if my wishes are unknown, shall be consistent with my best interest.

_____ Print Name of Patient	_____ Date of Birth
_____ Signature of Patient, Parent, Guardian or Patient Representative	_____ Today's Date
_____ Signature and Title of SYTHC Employee	_____ Today's Date