My Community Dental Centers

Chart #:

SUBSTITUTE AUTHORIZATION (MINOR CHILD)

Date: _____

Patient Name: _____ Patient DOB: _____

I, _____, as parent/legal custodian of the above named minor child, hereby authorize the following individual(s) listed to attend my child's appointment at MCDC in my absence, consent to any treatment based on the current treatment plan, and communicate with the staff at MCDC regarding my child's care. This includes the authority to receive any and all confidential/protected health information* in the possession of MCDC as required for coordination of care, without violation of any applicable Federal or state laws. I understand that any substitute must be 18 years of age or older, and I agree to inform my substitute to provide photo I.D. to MCDC staff at the time of the appointment.

Name of Individual(s)	Relationship to Child
_____	_____
_____	_____
_____	_____

* "Confidential health information" means information concerning the patient made confidential or protected by Federal law.

IMPORTANT NOTICE: If my child attends the appointment alone or with an individual not authorized by this document, I understand that MCDC has the right not to treat my child at that time and to reschedule the appointment.

Revocation: Except as otherwise provided by law, I may revoke this Authorization by notifying MCDC in writing, or effective as of a date certain if noted below.

_____ Valid until revoked in writing
_____ Authorization to expire on ____/____/____

A COPY OF THIS AUTHORIZATION SHALL BE DEEMED AS VALID AS THE ORIGINAL

_____ _____

Parent/Legal Custodian Signature Parent/Legal Custodian Printed Name

My Community Dental Centers

Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Birth Date: _____ Gender: __ Family Status: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Address: _____
Street Apartment #

_____
City State Zip Code

Preferred appointment reminder: ☐ Voice Message ☐ Text Message ☐ Email

Emergency Contact Person: _____ Relation to Patient: _____

Phone Number: _____

Health Information

Please Note: All of the following information is needed to allow us to treat you safely and will be kept CONFIDENTIAL.

Please check where you receive your medical care:

☐ Doctor's Office_____ Primary Care Provider:_____ ☐ Urgent Care/Emergency Room ☐ FQHC

PLEASE CHECK ALL THAT APPLY:

MEDICAL HISTORY

- ☐ ADD/ ADHD
- ☐ AIDS/HIV+
- ☐ Alcoholism
- ☐ Alzheimer's Disease
- ☐ Aortic Stenosis
- ☐ Arthritis/Osteoarthritis
- ☐ Asthma
- ☐ Auto-immune Disease
  - ☐ Rheumatoid
  - ☐ Fibromyalgia
  - ☐ Lupus
- ☐ Blood Disorder: _____
- ☐ Cancer:_____
  - ☐ Chemotherapy
  - ☐ Radiation
- ☐ Cataracts
- ☐ Cleft Palate
- ☐ Concussion / Head Injury
- ☐ COPD / Emphysema
- ☐ Dementia
- ☐ Depression
- ☐ Developmental Disabilities
- ☐ Diabetes
  - ☐ Stasis Ulcers
  - ☐ Hypoglycemia
- ☐ Eating Disorders
  - ☐ Anorexia
  - ☐ Bulimia
- ☐ Epilepsy / Seizures
- ☐ Gastro-intestinal Disorders
  - ☐ Heartburn / Indigestion
  - ☐ Ulcers
- ☐ Heart Disease
  - ☐ Heart Attack:_____
  - ☐ Heart Failure
- ☐ Hepatitis / Liver Disease
- ☐ High Blood Pressure / HTN
- ☐ Kidney Disease
- ☐ Mitral Valve Prolapse
- ☐ Multiple Sclerosis
- ☐ Postural Hypotension
- ☐ Pregnancy –Due Date:_____
- ☐ Psychiatric Disorders
- ☐ Sleep Disorders
  - ☐ CPAP
- ☐ Stroke / CVA: _____
  - ☐ Paralysis L- R
  - ☐ Weakness L- R
  - ☐ Aphasia
- ☐ Thyroid Disorders
- ☐ Tuberculosis
- ☐ Venereal Disease / STD

COMMON SYMPTOMS

- ☐ Abnormal Heart Beat / Arrhythmia
- ☐ Angina / Chest Pain
- ☐ Anxiety
- ☐ Bruise Easily
- ☐ Chronic Back Pain
- ☐ Chronic Hoarseness / Cough
- ☐ Constipation
- ☐ Difficulty Swallowing/ Dry Mouth
- ☐ Dizziness
- ☐ Fainting
- ☐ Forgetfulness / Memory Loss
- ☐ Hives / Eczema
- ☐ Increased Thirst
- ☐ Migraines / Headaches
- ☐ Nausea / Vomiting
- ☐ Neuritis / Neuralgia / Sciatica
- ☐ Recent-Dramatic Weight Loss
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Swelling of Hands /Feet

SURGICAL HISTORY

- ☐ Artificial Joints:_____
- ☐ Heart Surgery: _____
  - ☐ Artificial Valve
  - ☐ Heart Murmur
  - ☐ Coronary Artery Bypass
- ☐ Implantable Cardiac Defibrillator
- ☐ Pacemaker
- ☐ Other Surgery:_____

Please place other health related issues you may be experiencing here:

_____

_____

_____

My Community Dental Centers

MEDICATION SPECIFIC QUESTIONS

- Have you ever taken any of the following medications for Osteoporosis, Bone Cancer or Osteoarthritis?
  - ☐ Alendronate (Fosamax) Pamidronate (Aredia)
  - ☐ Alendronate & Cholecalciferal (Fosamax Plus)
  - ☐ Clondronate (Bonefes, Clasteon)
  - ☐ Etidronate & Calcium (Calcium Carbonate, Didrocal)
  - ☐ Etidronate Disodium (Didronel)
  - ☐ Ibandronate (Boniva)
  - ☐ Pamidronate (Aredia)
  - ☐ Risedronate (Actonel)
  - ☐ Ridedronate & Calcium (Actonel & Calcium)
  - ☐ Tiludronate (Skelid)
  - ☐ Xgeva (Denosumab)
  - ☐ Zoledronic Acid (Reclast, Zometa)
  - ☐ Any Other Bisphosphonate Medication:_____
- Have you ever taken the prescription drugs Flenfluramine, Flenfluramine with Phentermine (fen-phen), dexfenfluramine (Redux or Pondimin) or other weight loss products? ☐ No ☐ Yes If so, When:_____ Did you have a follow up Echocardiogram: ☐ No ☐ Yes
- Are you or have you ever taken a Blood Thinning Medication such as Coumadin/Warfarin, Pradaxa, Plavix, Aspirin or Other? ☐ No ☐ Yes
- Have You Been on Steroid Therapy in the Last 6 Months? ☐ No ☐ Yes If so, when:_____ Name of Drug: _____

PLEASE LIST ALL CURRENT MEDICATIONS (DOSAGE AND TIME YOU TAKE THEM)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

PLEASE LIST ALL KNOWN ALLERGIES

☐ Penicillin ☐ Sulfa ☐ Aspirin ☐ Codeine ☐ Morphine ☐ Erythromycin ☐ Latex

Other Drug Allergies:_____

PERSONAL HEALTH HABITS

- Do you use tobacco products? ☐ No ☐ Yes Have you tried to quit? ☐ No ☐ Yes Do you want to know about quitting? ☐ No ☐ Yes
  ☐ Cigarettes ☐ Cigars ☐ Chewing Tobacco ☐ Snuff If so, How long have you used? _____ How much do you use each day?_____
- Do you drink alcohol? ☐ No ☐ Yes ☐ Beer ☐ Liquor ☐ Wine ☐ Other
  How long have you drank alcohol? _____ How often do you drink alcohol? _____ Do you think you drink too much? ☐ No ☐ Yes
- Do you drink any of the following beverages? ☐ No ☐ Yes ☐ Coffee ☐ Pop (Diet/Reg) ☐ Tea If so, How often? _____
- Do you use recreational/street drugs? ☐ No ☐ Yes If so, what:_____ How often: _____ How long:_____

  When Did You Last Use?_____ **(It is very important that you are honest about this because it can affect your treatment.)**

IMPORTANT ADDITIONAL INFORMATION

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ No ☐ Yes
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ No ☐ Yes
  If yes, please explain:_____ Name of Physician: _____
- Do you have any health problems that need further clarification? ☐ No ☐ Yes
  If yes, please explain:_____

_____ ___/___/____
PATIENT (PARENT/GUARDIAN) SIGNATURE DATE

_____ ___/___/____
DDS SIGNATURE DATE

My Community Dental Centers

Adult Dental History

Purpose of your Visit: _____

Are you aware of a problem? _____

How long since your last dental visit? _____

- Do you clench or grind your teeth? ☐ No ☐ Yes
- Have your ever experienced any pain or soreness in the muscles of your face Or around your ear or jaw click or pop? ☐ No ☐ Yes
- Are any of your teeth sensitive? ☐ No ☐ Yes
- Do your gums bleed or hurt? ☐ No ☐ Yes
- Are you pleased with the appearance of your teeth? ☐ No ☐ Yes
- Have you ever had gum treatment or surgery? ☐ No ☐ Yes
- Have you had any orthodontic treatment? ☐ No ☐ Yes
- Do you have a dental prosthesis (partial or complete denture)? ☐ No ☐ Yes

  If YES when was it made? Month _____ Year _____
- Are you interested in getting replacements? ☐ No ☐ Yes
- Have you had an unpleasant dental experience or is there anything about dentistry that your strongly dislike? ☐ No ☐ Yes
- Have you ever had to be pre-medicated with antibiotics or sedatives before dental treatment? ☐ No ☐ Yes

Please sign below

Child/Teen Dental History

- Is this your child's first visit to the dentist? ☐ No ☐ Yes
- If not, how long since their last visit?_____
- How often does your child brush their teeth? _____
- Does your child suck his/her thumb or fingers? ☐ No ☐ Yes
- Have there been injuries to teeth from falls or blows that could cause chips? ☐ No ☐ Yes
- Has your child had any problem with dental treatment in the past? ☐ No ☐ Yes
- Do you or your child think there is anything wrong with his/her teeth? ☐ No ☐ Yes

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

_____ ___/___/____
PATIENT (PARENT/GUARDIAN) SIGNATURE DATE

_____ ___/___/____
DDS SIGNATURE DATE

My Community Dental Centers

WELCOME TO MCDC

We are honored you have made an appointment with us for yourself, your child, or a person in your care, and for allowing us to provide your dental care. Our goal is to provide quality services and continually strive to improve our patients' experiences. You may receive a phone call from Press Ganey which is an outside survey company that we have partnered with to receive your valuable input.

APPOINTMENT REMINDER

MCDC provides a courtesy reminder for reserved appointments approximately one week prior to the appointment, as well as 1-2 days in advance. Appointment reminders may be sent by voice message, text message, or email. If you have any questions about these notifications, please call the center directly. **We may require a confirmation response from you that you will be in attendance for your reserved appointment.** If we do not receive a confirmation of your appointment, or we are unable to reach you, your appointment may be cancelled. Please be sure that the contact information we have on file for you is current and accurate at all times to avoid missing your courtesy reminder. If we are unable to reach you, your appointment may be cancelled.

BROKEN APPOINTMENT/CANCELLATION POLICY

Regular dental visits every 6 months, including examinations, cleanings, fluoride treatments, dental sealants, and fillings are important to keep teeth healthy. It is especially important that you keep your appointment! Valuable time has been reserved for you, or your child's care. A missed appointment results in lost time which could be used for another patient waiting to receive treatment.

If you fail to show for a reserved appointment, any appointments you have scheduled will be cancelled. We require 24 hour notice when canceling or rescheduling an appointment that has been reserved for you. Any combination of failing to give adequate cancellation notice, or not showing up for an appointment, may result in **DISMISSAL** from **all MCDC** center locations.

EMERGENCY CARE

Patients who have been dismissed from the center for either broken appointments, or cancellation reasons, will be notified by certified letter and will be seen for EMERGENCY care only for 30 days from the date of the dismissal letter.

MINOR PATIENT APPOINTMENTS

MCDC providers are required to discuss and obtain permission BEFORE providing treatment to all minor patients. (Children under the age of 18) An adult MUST be present in the center throughout the duration of the child's appointment. IF a parent is unable to bring the child to the appointment, there is a consent form that can be signed to authorize another adult permission to approve treatment plan procedures. Please request this form in advance of the reserved appointment.

HOME CARE

It is important to maintain regular 6 month checkup appointments, as well as maintain excellent home care and proper diet. If you **do not** keep on a regular 6 month schedule, maintain excellent home care and proper diet, MCDC **cannot** be held responsible if restorative care fails. Failure of the restoration due to neglect of oral hygiene and a high sugar/high carbohydrate diet is the responsibility of the patient and not the dentist. Failure of any restoration within a two year time period, and the required follow up repair or extraction will be at the patient's expense. I understand and consent to having restorations completed with these guidelines.

My Community Dental Centers

SMOKE FREE CAMPUS

In order to maintain a safe and healthy work environment, MCDC is a smoke free campus. This means that employees, patients, and vendors are prohibited from smoking on the grounds or within sight of any MCDC building. Smoking is defined as the "act of lighting, smoking, or carrying a lighted or smoldering cigar, cigarette, e-cigarette, or pipe of any kind".

BEHAVIOR

Seeking and receiving medical care can be stressful and anxiety provoking. For the sake of all individuals involved, civil behavior with proper respect, courtesy and manners must be maintained and observed. There is also a zero tolerance for alcohol, drugs, smoking, or weapons on MCDC property. Individuals who use foul language, display threatening or violent behavior, or do not comply with our zero tolerance policy, will be immediately dismissed from all MCDC centers. In an effort to better serve you, cell phone use is not allowed beyond the reception area.

NOTICE OF PRIVACY

MCDC respects my right to privacy and confidentiality of my personal health information. I acknowledge that I have been informed of and offered a copy of the *Notice of Privacy Practices.*

CONSENT TO TREATMENT

I have read the above policy and agree to abide by it.

I HEREBY GIVE CONSENT TO My Community Dental Centers to provide treatment to:

_____, (check one) ◯ myself, ◯ my child, ◯ my ward, those procedures and treatments, including local anesthesia, which are deemed necessary. I consent to any x-ray, examination, anesthetic, sedative, or dental treatment rendered under the general, direct or indirect supervision of the dentist and his/her associates and/or staff members, as he/she may deem necessary.
Information about your appointment may be shared with your medical provider.
This authorization will remain in effect until canceled in writing by me.

I have read the above policy and agree to abide by it.