Consent to Treatment, Assignment of Benefits & Release of Information

Name of Child: _____ Date of Birth: _____

Adult Providing Consent: _____ Relation to Child: _____

- If you do not want your child to be seen, please initial here _____ and return this form.
- With my signature below, I authorize Open Door Community Health Centers to provide diagnosis and/or treatment of dental conditions for the above-named child through the Mobile Dental Program.
- I understand that Open Door Community Health Centers will provide only those services that I have authorized below. I have signed next to each type of service for which I am granting authorization:

_____ **Dental Exam**, including dental x-rays

_____ **Preventive Services**: tooth cleaning, oral hygiene instruction, sealants, fluoride treatment

_____ **Restorative Services**: filling, stainless steel crown, pulpotomy, root canal *Anesthesia is used for these procedures*

_____ **Extraction of Primary Teeth**: Removal of primary (baby) teeth that can not be restored through other treatments. *Anesthesia may be used for this procedure.*

*If **extraction of permanent teeth** is recommended, a separate consent form will be required.*

- I understand that mobile dental visits are scheduled during school hours. I have checked one box below to indicate whether or not I want to present when my child is seen. ***I understand that there is insufficient room in the mobile dental van to allow me to be present in the treatment area, but that I may wait nearby during my child's visit(s).***

☐ I want to be present at all of my child's dental appointments.

☐ I want to be present only at my child's dental appointments for restorative services or extractions.

☐ I want to be present only at my child's dental appointments for extractions.

☐ I do not need to be present at my child's dental appointments.

If you have requested to be present, we will call you with dates and times of your child's appointments. Please provide contact information below:

Daytime phone number(s): _____

- I have received a copy of the Notice of Privacy Practices of Open Door Community Health Centers. I understand that Open Door Community Health Centers shares certain types of information with other health care providers, public agencies and payors, as a part of our health care operations. I understand that I have the right to request that specific information not be shared, and that I should request more information if I have questions or concerns.
- *For patients with Healthy Families or Medi-cal*: You must present your current Healthy Families or Medi-Cal card.
- I certify, under penalty of perjury, that the information provided is true and correct to the best of my knowledge.

Signature of Parent or Legal Guardian: _____ Date: _____

OPEN DOOR COMMUNITY HEALTH CENTERS **PATIENT INFORMATION**

Last Name: _____ **First Name:** _____ MI: _____

Social Security Number: _____ **Date of Birth**: _____

Address (mailing): _____ **City:** _____ **Zip Code:** _____

Address (street): _____ City: _____ Zip Code: _____

Telephone: _____ May we contact you at home? ☐ Yes ☐ No

Other Contact: ☐ Message ☐ Pager ☐ Cell Phone _____

Sex: ☐ Male ☐ Female ☐ Trans: Male to Female ☐ Trans: Female to Male

Other names you have used: _____

Are Interpreter Services Needed? ☐ Yes ☐ No

Primary Language: ☐ English ☐ Spanish ☐ Hmong ☐ Other: _____

Where do you currently live?: ☐ In my home or apartment ☐ At a shelter ☐ Staying with others
☐ In transitional housing ☐ The street, a camp, under a bridge, or in a car

Migrant Status: ☐ Migrant ☐ Seasonal ☑ Neither **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Veteran Status: ☐ Yes ☐ No

Race: ☐ White ☐ Asian ☐ American Indian ☐ African American ☐ Pacific Islander ☐ Alaskan Native ☐ Unknown

Employer Name: _____ Phone #: _____

Emergency Contact Information (for patient, or for responsible party if patient is a minor):

Emergency Contact Name: _____ Phone #: _____

Relationship to Patient: ☐ Spouse ☐ Mother ☐ Father ☐ Grandparent ☐ Other _____

Other Contact ☐ Message ☐ Pager ☐ Cell Phone ☐ Email ☐ Confidential _____

Medi-Cal ID Number: _____ Issue Date: _____

Guarantor Information (The person responsible for payment, example: a parent for a patient under 18 years of age)

Last Name: _____ **First Name:** _____ MI: _____

Billing Address: ☐ same as above _____ City/Zip: _____

Relationship to patient: ☐ Parent ☐ Spouse ☐ Other: _____ **Social Security Number**: _____

Gender: ☐ Male ☐ Female **Date of Birth:** _____ **Telephone:** _____

Income information: *Information provided is used to offer discounts to you.*

Family Income: $_____ per ☐ Year ☐ Month ☐ Week # of persons in Family: _____
☐ Declined

Entered by: _____ **Date:** _____

Housing and Income Information

Sliding Fee Discount Program

opendoor Community Health Centers

Why we ask for this information

Open Door Community Health Centers receive grants and federal funding to support our services. Each year we must collect information about the communities we serve to share with our funders. By completing this form, you are helping us keep our funding so we can offer more services.

We combine your information with others and report it in summary form. We do not share any personal information or report data that could be used to identify you.

---

1. Information about you and where you live

Name	**Birth date**	**MRN** *Office Use*

Are you a veteran? (Check one) ☐ Yes ☐ No

How do you describe where you live? (Check one)

- ☐ Live in a place I own or rent (house, apartment, condo, or townhouse)
- ☐ Live in someone else's place on a temporary basis ("couch surfing")
- ☐ Live in transitional housing (Arcata House or halfway house)
- ☐ Live somewhere as part of a program or treatment (hospital, hotel or motel, respite care, treatment program, jail)
- ☐ Live in emergency shelter
- ☐ Live unsheltered (in a tent, car, around buildings or bridges)

At any time in the last 12 months were you without a regular place to live? (Check one) ☐ Yes ☐ No

2. Information about the people in your household

Please list the names and birth dates of the people in your household. Your household includes people you live and share an income with.

Name	**Birth date**	**MRN** *Office Use*

3. Information about household income

What is your household income before taxes or deductions? This is the total amount earned by all members of your household, including you.

Examples of income (check all that apply):

- ☐ Wages or salary from employment or self-employment
- ☐ Other earnings from employment, such as tips or commissions
- ☐ Child Support
- ☐ Spousal Support
- ☐ Alimony
- ☐ Pension or Retirement income
- ☐ Social Security
- ☐ Disability payments
- ☐ Unemployment payments
- ☐ Any other source of income_____

Total household income: $_____

Is this income (Check one) ☐ Weekly ☐ Monthly ☐ Annually

4. Eligibility for sliding fee discount scale co-payment

Based on your household income reported above you may be eligible for a discount on the fees for your services.

If you are reporting no income above, you must describe your current means of support and/or living situation:

_____

We reserve the right to request evidence of your income in the form of pay stubs, tax returns, or other documents in order to qualify for discounts.

5. Certification and signature

I declare that the information I have given on this form is true, correct, and complete. I understand that the giving of false information may make me ineligible for discounted services.

Signature: _____ Date: _____

OFFICE USE ONLY SITE_____ Calculated Annual Income_____

Income Verified*: ☐ Yes (Expires 365 days) ☐ No (≤200% FPL-Expires 30days) ☐ No (>200% FPL- Expires 365days)

Notified Patient about eligibility screening and application assistance through Open Door Member Services: ☐ Yes

This applicant is: ☐ Eligible for Discount of: ☐ A Scale ☐ B Scale ☐ C Scale ☐ D Scale ☐ $0 Co-pay**
☐ Not Eligible for Sliding Scale Discount ☐ Patient Declined

**$0 co-pay requires re-certification by Office Manager at each visit and cannot be applied to family members.

Termination date: _____ Certified by: Signature: _____ Date: _____

Document eligibility for each family member for each account type within registration.
Enter date eligibility begins (the certification date on this sheet) for each eligible account.
Scan form into Documents under FDS – Financial Document, DESC – FPL.

*ROUTE TO MEMBER SERVICES for follow-up assistance: 1) any form for patient eligible for SFS≤200% and not yet verified; and/or 2) any form for patient with no primary coverage (or no coverage other than SFS)

Open Door Community Health Centers - Dental Health History

PLEASE ANSWER THE FOLLOWING QUESTIONS.
For Yes/No questions, **please mark each question individually.**
If you are uncertain how to respond to a question, please tell your dentist.

Patient Name *First*_____ *Last*_____Date of Birth_____Sex

☐ Male ☐ Female ☐ Transgender

1. When was your last dental visit? _____ When were your last dental X-Rays? _____ At what dentist or office? _____
2. When was your last medical exam? _____ Who is your medical doctor? _____
3. How is your health in general? ☐ Excellent ☐ Fair ☐ Good ☐ Poor
4. Do you smoke or use tobacco? ☐ No ☐ Yes If Yes: How many years? _____ How many packs per day? _____
5. Women: Are you currently pregnant or nursing? ☐ No ☐ Yes

6. Medical History: Have you ever had...

	No	Yes
A. Abnormal blood pressure (high or low)	☐	☐
B. Allergies (hay fever or environmental)	☐	☐
C. Arthritis	☐	☐
D. Back or Neck Injury/Pain	☐	☐
E. Blood disorder, anemia	☐	☐
1. Abnormal bleeding with surgery or trauma	☐	☐
2. Bruising easily	☐	☐
F. Cancer / Radiation /Chemotherapy therapy	☐	☐
G. Cardiovascular (heart) disease	☐	☐
1. Chest pain during/after exertion	☐	☐
2. Shortness of breath	☐	☐
3. Swelling of ankles or feet	☐	☐
4. Cardiac pacemaker/defibrillator	☐	☐
H. Congenital heart lesion/anomaly	☐	☐
I. Artificial heart valve or stent	☐	☐
J. Diabetes	☐	☐
K. Fainting spells	☐	☐
L. Hepatitis, A, B, C other jaundice or liver disease	☐	☐
M. HIV or AIDs	☐	☐
N. Hives or skin rash	☐	☐
O. Kidney trouble	☐	☐
P. Lung trouble, Asthma, Emphysema, Tuberculosis	☐	☐
Q. Persistent or bloody cough	☐	☐
R. Prosthetic (circle): Joint, implant, bone plate or screw	☐	☐
S. Seizures	☐	☐
T. Sinus problems	☐	☐
U. Stomach ulcer	☐	☐

7. Dental History: Do you *currently* have...

A. Bleeding gums	☐	☐
B. Clenching or grinding teeth	☐	☐
C. Teeth sensitive to hot or cold	☐	☐
D. Unpleasant odor or taste in mouth	☐	☐

8. If you are taking any medications, please list all medications you are taking on the Current Medications form.

9. Medications: Are you taking...

	No	Yes
A. Antibiotics or sulfa drugs	☐	☐
B. Anticoagulants (blood thinners)	☐	☐
C. Antihistamines	☐	☐
D. Aspirin	☐	☐
E. Bisphosphonate (for treatment of bones, etc.)	☐	☐
F. Cortisone or other steroids	☐	☐
G. Heart drugs, nitroglycerin, digitalis	☐	☐
H. Insulin or other diabetes drugs	☐	☐
I. Medicine for high blood pressure	☐	☐
J. Oral contraceptives	☐	☐
K. Tranquilizers	☐	☐
L. *Other medications (list on Medications form)*	☐	☐

☐ **Check here if not taking any medications.**

10. Allergies: Have you ever had a reaction to...

	No	Yes
A. Aspirin/Ibuprofen	☐	☐
B. Codeine or other narcotics	☐	☐
C. Iodine	☐	☐
D. Latex or rubber products	☐	☐
E. Local anesthetic	☐	☐
F. Penicillin or Amoxicillin	☐	☐
G. Other Antibiotics	☐	☐
H. Sedatives or tranquilizers	☐	☐
I. Sulfa drugs	☐	☐
J. *Other medications (list on Medications form)*	☐	☐

☐ **Check here if no known allergies.**

11. Have you ever been treated in a Hospital? (Y/N)

_____

_____

12. List other diseases or problems not listed:

_____

_____

- **I have read a copy of the bisphosphonate alert.**
- **I have read the above and have filled out this health history completely, to the best of my ability.**

Signature (of Patient or Responsible Party): _____ Date: _____

OFFICE USE ONLY

Review Date: _____ **Dentist:** _____ **Review Date:** _____ **Dentist:** _____

Open Door's Member Services Referral Form

ASSISTANCE IS FREE!

Humboldt:
Phone: (707) 269-7073
Fax: (707) 269-7045

Del Norte:
Phone: (707) 465-1988
Fax: (707) 465-1987

Member Services can help with:

- Applications for Health Care Benefits or Coverage
- Food resource assistance
- Health care access questions
- *And More!*

Date:

Name

Date of Birth:

Name of Parent/Guardian (if applicable)

Daytime Phone:

Email:

Address:

Referred From:

- ☐ Mobile Dental
- ☐ Open Door Site:
- ☐ Other:

Patient Acknowledgment of Receipt of Dental Materials Fact Sheet

I,_____, acknowledge I have received from Open Door
Patient Name
Community Health Centers, a copy of the Dental Materials Fact Sheet dated October 2001.

*Patient Signature*_____ *Date*_____

The Dental Board of California
Dental Materials Fact Sheet
Adopted by the Board on October 17, 2001

As required by Chapter 801, Statutes of 1992, the Dental Board of California has prepared this fact sheet to summarize information on the most frequently used restorative dental materials. Information on this fact sheet is intended to encourage discussion between the patient and the dentist and not intended to be a complete guide to dental materials science.

The most frequently used materials in restorative dentistry are amalgam, composite resin, glass ionomer cement, resin-ionomer cement, porcelain (ceramic", porcelain (fused-to-metal), gold alloys (noble) and nickel or cobalt-chrome (base-metal) alloys. Each material has its own advantages and disadvantages, benefits and risks. These and other relevant factors are compared in the attached matrix titled "Comparisons of Restorative Dental Materials". A "Glossary of Terms" is also attached to assist the reader in understanding the terms used.

The statements made are supported by relevant, credible dental research published mainly between 1993 – 2001. In some cases, where contemporary research is sparse, we have indicated our best perceptions based upon information that predates 1993.

The reader should be aware that the outcome of dental treatment or durability of a restoration is not solely a function of the material from which the restoration was made. The durability of any restoration is influenced by the dentist's technique when placing the restoration, the ancillary materials used in the procedure, and the patient's cooperation during the procedure. Following restoration of the teeth, the longevity of the restoration will be strongly influenced by the patient's compliance with dental hygiene and home care, their diet and chewing habits.

Dental Materials Fact Sheet

What About the Safety of Filling Materials?

Patient health and the safety of dental treatments are the primary goals of California's dental professionals and the Dental Board of California. The purpose of this fact sheet is to provide you with information concerning the risks and benefits of all the dental materials used in the restoration (filling) of teeth.

The Dental Board of California is required by law* to make this dental materials fact sheet available to every licensed dentist in the state of California. Your dentist, in turn, must provide this fact sheet to every new patient and all patients of record only once before beginning any dental filling procedure.

As the patient or parent/guardian, you are strongly encouraged to discuss with your dentist the facts presented concerning the filling materials being considered for your particular treatment.

** Business and Professions Code 1648.10-1648.20*

Allergic Reactions to Dental Materials

Components in dental fillings may have side effects or cause allergic reactions, just like other materials we may come in contact with in our daily lives. The risks of such reactions are very low for all types of filling materials. Such reactions can be caused by specific components of the filling materials such as mercury, nickel, chromium, and/or beryllium alloys. Usually, an allergy will reveal itself as a skin rash and is easily reversed when the individual is not in contact with the material.

There are no documented cases of allergic reactions to composite resin, glass ionomer, resin ionomer, or porcelain. However, there have been rare allergic responses reported with dental amalgam, porcelain fused to metal, gold alloys, and nickel or cobalt-chrome alloys.

If you suffer from allergies, discuss these potential problems with your dentist before a filling material is chosen.

Toxicity of Dental Materials

Dental Amalgam

Mercury in its elemental form is on the State of California's Proposition 65 list of chemicals known to the state to cause reproductive toxicity. Mercury may harm the developing brain of a child or fetus.

Dental amalgam is created by mixing elemental mercury (4354%) and an alloy powder (46-57%) composed mainly of silver, tin, and copper. This has caused discussion about the risks of mercury in dental amalgam. Such mercury is emitted in minute amounts as vapor. Some concerns have been raised regarding possible toxicity. Scientific research continues on the safety of dental amalgam. According to the Centers for Disease Control and Prevention, there is scant evidence that the health of the vast majority of people with amalgam is compromised.

The Food and Drug Administration (FDA) and other public health organizations have investigated the safety of amalgam used in dental fillings. The conclusion: no valid scientific evidence has shown that amalgams cause harm to patients with dental restorations, except in rare cases of allergy. The World Health Organization reached a similar conclusion stating, "Amalgam restorations are safe and cost effective."

A diversity of opinions exists regarding the safety of dental amalgams. Questions have been raised about its safety in pregnant women, children, and diabetics. However, scientific evidence and research literature in peer-reviewed scientific journals suggest that otherwise healthy women, children, and diabetics are not at an increased risk from dental amalgams in their mouths. The FDA places no restrictions on the use of dental amalgam.

Composite Resin

Some Composite Resins include Crystalline Silica, which is on the State of California's Proposition 65 list of chemicals known to the state to cause cancer.

It is always a good idea to discuss any dental treatment thoroughly with your dentist.

DENTAL AMALGAM FILLINGS

Dental amalgam is a self-hardening mixture of silver-tin-copper alloy powder and liquid mercury and is sometimes referred to as silver fillings because of its color. It is often used as a filling material and replacement for broken teeth.

Advantages

- ♥ Durable; long lasting
- ♥ Wears well; holds up well to the forces of biting
- ♥ Relatively inexpensive
- ♥ Generally completed in one visit
- ♥ Self-sealing; minimal-to-no shrinkage and resists leakage
- ♥ Resistance to further decay is high, but can be difficult to find in early stages
- ♥ Frequency of repair and Replacement is low

Disadvantages

- Refer to "What About the Safety of Filling Materials"
- Gray colored, not tooth colored
- May darken as it corrodes; may stain teeth over time
- Requires removal of some healthy tooth
- In larger amalgam fillings, the remaining tooth may weaken and fracture
- Contact with other metals may cause occasional, minute electrical flow

The durability of any dental restoration is influenced not only by the material it is made from but also by the dentist's technique when placing the restoration. Other factors include the supporting materials used in the procedure and the patient's cooperation during the procedure. The length of time a restoration will last is dependent upon your dental hygiene, home care, and diet and chewing habits.

COMPOSITE RESIN FILLINGS

Composite fillings are a mixture of powdered glass and plastic resin, sometimes referred to as white, plastic, or tooth-colored fillings. It is used for fillings, inlays, veneers, partial and complete crowns, or to replacement for broken teeth.

Advantages

- ♥ Strong and durable
- ♥ Tooth colored
- ♥ Single visit for filling
- ♥ Resists breaking
- ♥ Maximum amount of tooth preserved
- ♥ Small risk of leakage if bonded only to enamel
- ♥ Does not corrode
- ♥ Generally holds up well to the forces of biting depending on product used
- ♥ Resistance to further decay is Moderate and easy to find
- ♥ Frequency of repair or replacement is low to moderate

Disadvantages

- Refer to "What About the Safety of Filling Materials"
- Moderate occurrence of tooth sensitivity; sensitive to dentist's method of application
- Costs more than dental amalgam
- Material shrinks when hardened and could lead to further decay and/or temperature sensitivity
- Requires more than one visit for inlays, veneers, and crowns
- May wear faster than dental enamel
- May leak over time when bonded beneath the layer of enamel

opendoor
Community Health Centers

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to provide this information to all individuals that request and obtain services at Open Door Community Health Centers. We do this by posting a summary of this Notice in the reception area of each of our health centers, and by providing this Notice in our patient information packet. Should our privacy practices change in the future, we will notify patients by promptly posting our new policy and by making revised Notices available to all patients.

How we use information about you

- We ask each patient to complete a Consent to Treatment form. This consent gives us permission to use and disclose your individual information for healthcare and business operations. This means you allow us to share your information when it is needed to provide care, coordinate health services, and obtain payment for those services.
- We request from you only the information that we need for health care and business operations. This information includes your health history and basic personal information. Examples of this are your address, phone number, insurance information, social security number, and family income.
- We limit access to your information to those employees that need the information in order to do their jobs. For example, billing staff use your personal information in order to bill for services, but do not access your personal health history.
- We share information about you with others that are involved in your health care. For example, we send basic information (such as services received and diagnoses) to insurances or programs that pay for the services. Another example is when your health care provider refers you to a specialist. Your provider sends related sections of your medical history to the specialist. These types of disclosures are directly related to the health care that we provide or coordinate and are allowed under your Consent to Treatment.
- We disclose some information in very specific situations that are required by law for example to report abuse, violence or neglect, or to report communicable diseases.
- As part of our management and quality improvement programs, we group your information with that of other patients for analysis. When this is done, your personal information is removed and it is no longer linked to you.
- We are a part of a health care collaborative called OCHIN. A current list of OCHIN members is available at www.ochin.org. As a business associate of ours, OCHIN supplies information technology and related services to us and other OCHIN members. OCHIN also engages in quality assessment and improvement activities on behalf of its members. For example, OCHIN coordinates clinical review activities on behalf of participating members. They do this to establish best practice standards and access medical benefits from the use of electronic health record systems. OCHIN also helps members work together to improve the management of internal and external patient referrals. We may share your health information with other OCHIN members when necessary for health care operation purposes.

- We may participate in one or more health information exchanges (HIEs). HIEs may electronically share medical information for treatment, payment and health care operation purposes with other participants in the HIEs. HIEs allow your health care providers to quickly access and use medical information necessary for your treatment and other lawful purposes. The addition of your medical information in a HIE is voluntary and subject to your right to opt-out. More information on any HIE in which we participate or how you can exercise your right to opt-out can be found at: https://www.nchiin.org/Optout.aspx

When we need your permission to disclose information

Any release of information about you that does not fall into the above categories requires a written authorization from you. You will be asked to complete an Authorization to Release form and to tell us exactly what sections of your information we can release, and to whom. If this form in not correct and complete, we can not release your individual information.

Your Rights Concerning your individual information

You have certain specific rights to control your individual health information. These rights are summarized below. We have policies and procedures in place regarding each of these items. You may contact your provider, or a medical records supervisor, for more information about any of these rights.

- **Right to revoke authorization** - You have the right to revoke a previously made authorization to release.
- **Right to request restrictions on disclosure** – You have the right to request that we not disclose all or part of your individual information, even for the health care and business operations discussed above. As a health care provider, we are not required to agree to your request, and we do not encourage any restriction that would impact the sharing of information that is important to maintaining your health. However, there may be situations when such a restriction is appropriate. You are encouraged to discuss this with your health care provider who will provide you with more information should a restriction be necessary.
- **Right to access your health care records** - You have the right to inspect your health care records in the presence of a health care provider, and to have a copy of those records.
- **Right to amend or correct your health care records** – You have the right to provide a written addendum to correct any portion of your health care record that you feel is inaccurate.
- **Right to know how your records have been disclosed** - You have the right to receive a history of the disclosures of your health care records.

What to do if you suspect that your privacy has been violated

We encourage our staff to report any suspected privacy violations, either intentional or unintentional. We also encourage you to make a report any time that you feel your privacy may have been violated. No individual will ever be discriminated against for making a report.

You may make a report in the following ways:

- Phone: (707) 826-8633 x 5176
- Fax a report to: (707) 445-0289 Attn: Privacy Officer
- Email: privacyofficer@opendoorhealth.com
- Send a written report to: Open Door Community Health Centers
  Attn: Privacy Officer
  1275 8th Street
  Arcata, CA 95521