Santa Ynez Tribal Health Clinic

PATIENT INTAKE

Please provide us with your insurance and valid ID

PATIENT'S INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	NICKNAME

SOCIAL SECURITY NUMBER	BIRTHDATE	SEX ☐ MALE ☐ FEMALE	MOTHER'S MAIDEN NAME (FOR PURPOSES OF IMMUNIZATION REGISTRY)

PATIENT'S BILLING/MAILING ADDRESS

STREET OR PO BOX		
CITY	STATE	ZIP

PATIENT'S PHYSICAL ADDRESS (if different from billing/mailing address)

STREET ADDRESS		
CITY	STATE	ZIP

PATIENT'S CONTACT INFORMATION

HOME PHONE #	DAY PHONE #	ALTERNATE PHONE	E-MAIL ADDRESS

Preferred Method for Notifications (check all that apply) ☐ Phone ☐ Text ☐ E-mail ☐ Automated Recordings

PATIENT'S EMERGENCY CONTACT INFORMATION

NAME	ADDRESS	RELATIONSHIP	CONTACT PHONE NUMBER

PATIENT'S ADDITIONAL INFORMATION – For Purposes of Grant Funding

RACE
- ☐ AMERICAN INDIAN/ALASKAN NATIVE
- ☐ ASIAN
- ☐ BLACK/AFRICAN AMERICAN
- ☐ NATIVE HAWAIIAN
- ☐ OTHER PACIFIC ISLANDER
- ☐ WHITE
- ☐ MORE THAN ONE RACE

IF NATIVE AMERICAN:

TRIBE OF MEMBERSHIP:_________________

BLOOD QUANTUM:______________

FATHER'S NAME:______________
MOTHER'S NAME:______________

PRIMARY LANGUAGE
- ☐ ENGLISH
- ☐ SPANISH
- ☐ OTHER ___________

ARE YOU OF HISPANIC OR LATINO ORIGIN?
☐ YES ☐ NO

MARITAL STATUS
- ☐ SINGLE
- ☐ MARRIED
- ☐ DIVORCED
- ☐ WIDOW
- ☐ LEGALLY SEPARATED
- ☐ LIFE PARTNER
- ☐ OTHER ___________

HOUSEHOLD SIZE

☐ 1 ☐ 6
☐ 2 ☐ 7
☐ 3 ☐ 8
☐ 4 ☐ 9
☐ 5 ☐ 10

☐ OTHER _____

ESTIMATED HOUSEHOLD INCOME

$ ___________

- ☐ WEEKLY
- ☐ BI-WEEKLY
- ☐ MONTHLY
- ☐ ANNUALLY

ARE YOU A VETERAN OF THE U.S. ARMED FORCES?

☐ YES

☐ NO

IF YES, PLEASE PROVIDE THE RECEPTIONIST A COPY OF YOUR DD-214.

RESPONSIBLE PARTY'S INFORMATION (if different than patient)

NAME (Last, First, Middle)	PREVIOUS LAST NAME	NICKNAME

SSN	BIRTHDATE	SEX	RELATIONSHIP TO PATIENT

RESPONSIBLE PARTY'S BILLING/MAILING ADDRESS (if different than patient)

STREET OR PO BOX			
CITY	STATE	ZIP	HOME PHONE NUMBER

PATIENT'S EMPLOYER

NAME OF EMPLOYER	
TYPE OF BUSINESS	OCCUPATION
EMPLOYMENT STATUS ☐ FULL-TIME ☐ PART-TIME ☐ RETIRED ☐ DISABLED	

PRIMARY INSURANCE

TYPE OF PRIMARY COVERAGE ☐ MEDI-CAL ☐ MEDICARE ☐ PRIVATE INSURANCE ☐ NONE ☐ OTHER ______________

NAME OF INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER
ADDRESS OF INSURANCE COMPANY (Street, City, State, and Zip)	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if applicable)

NAME OF INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER
ADDRESS OF INSURANCE COMPANY (Street, City, State, and Zip)	EFFECTIVE DATE	EXPIRATION DATE

CONSENT FOR TREATMENT

I, the undersigned, certify that the information contained on this form is correct to the best of my knowledge. Furthermore, I authorize the release of any medical information necessary to process the claim for treatment, payment, or operations. I authorize payment of medical benefits to Santa Ynez Tribal Health Clinic (SYTHC), provider or suppliers for services. I hereby authorize the provider and whomever else he/she may designate as his/her assistant(s), to administer those treatments and procedures which in his/her opinion are deemed necessary. I hereby agree, regardless of insurance coverage, that I am responsible for all charges incurred. Payment is expected at the time of service. We will bill your insurance as a courtesy. I authorize SYTHC to contact me by mobile phone. (*Standard rates may apply.*)

Patient Signature____**Date** ________________

Responsible Party's Signature____ **Date** ________________

Witness ____ **Date** ________________

MEDICAL AND DENTAL HISTORY

Patient Name: ____ DOB:_______________________ Sex: ☐Male ☐Female

MEDICAL HISTORY

Name of Physician:____ Phone: ____

Physician's Address: ____

When was your last physical? ______________________________ Are you immunizations up to date? ___________________

Are you now under the care of a physician? ___________________ If yes, for what reason? _________________________________

Are you presently taking any medications/drugs/pills?___________ Please list: ____

Are you allergic (or have an adverse reaction) to?

☐ Penicillin ☐ Codeine ☐ Local Anesthetic ☐ Aspirin ☐ None ☐ Other ☐ Other Antibiotic

Please Describe: ____

Are you sensitive or allergic to latex? ____

If yes, please explain: ____

Have you had any unusual or unexplained reactions during a surgical procedure? ____

If yes, please explain: ____

Do you have, or have you had any of the following: (Yes or No)

	Y	N		Y	N		Y	N
Abnormal Blood Pressure	☐	☐	Epilepsy	☐	☐	Osteoporosis	☐	☐
Alcohol Addiction	☐	☐	Fainting Spells	☐	☐	Prolonged Bleeding	☐	☐
Anemia	☐	☐	Glaucoma	☐	☐	Prosthetic Implants	☐	☐
Anorexia	☐	☐	Hearing Impaired	☐	☐	Psychiatric Care	☐	☐
Arthritis/Rheumatism	☐	☐	Heart Disease/Surgery	☐	☐	Radiation Therapy	☐	☐
Artificial Heart Valve	☐	☐	Heart Murmur	☐	☐	Removal of Spleen	☐	☐
Artificial Joint	☐	☐	Heart Pace Maker	☐	☐	Rheumatic Fever	☐	☐
Asthma	☐	☐	Hemophilia	☐	☐	Rheumatic Heart Disease	☐	☐
Bulimia	☐	☐	Hepatitis	☐	☐	Sickle Cell Disease	☐	☐
Cancer	☐	☐	HIV Positive/ AIDS	☐	☐	Sinus Trouble	☐	☐
Chemical Dependency	☐	☐	Kidney Problems	☐	☐	Stroke	☐	☐
Chemotherapy	☐	☐	Learning Disability	☐	☐	Thyroid Problems	☐	☐
Congenital Heart Disease	☐	☐	Liver Disease	☐	☐	Tuberculosis	☐	☐
Cortisone Medicine	☐	☐	Lung Disease	☐	☐	Tumors	☐	☐
Diabetes	☐	☐	Mitral Valve Prolapse	☐	☐	Ulcers	☐	☐
Recreational Drugs	☐	☐	Neurological Disorders	☐	☐	Heart Stent	☐	☐
Emphysema	☐	☐	Organ Transplant	☐	☐			

Have you had any other serious illness, hospitalization or accident? ____

If yes, please explain: ____

Do you currently smoke or use the following tobacco products? ☐Cigarettes ☐Cigars ☐Pipe ☐Chew ☐None

Have you used tobacco products in the past? _____________________ If yes, how long ago? ____________________________

Do you drink alcoholic beverages? ____________________ If yes, how much? ____

WOMEN: Are you pregnant? ________Are you nursing? ______ Do you take birth control medications? _____________

Do you anticipate becoming pregnant? ________________

Date of Last Dental Visit: _____________________________

Yes	No	
☐	☐	Do your gums bleed while brushing or flossing?
☐	☐	Are your teeth sensitive to hot or cold liquids/foods?
☐	☐	Are your teeth sensitive to sweet or sour liquids/foods?
☐	☐	Do you feel pain to any of your teeth?
☐	☐	Do you have any sores or lumps in or near your mouth?
☐	☐	Have you had any head, neck or jaw injuries?
☐	☐	Do you have frequent headaches?
☐	☐	Do you clench or grind your teeth?
☐	☐	Do you bite your lips or cheeks frequently?
☐	☐	Have you ever experiences any of the following?

☐Clicking in Jaw ☐ Pain (joint, ear, side of face) ☐ Difficulty in opening or closing mouth ☐Difficulty in chewing

Yes	No	
☐	☐	Have you had any orthodontic work?
☐	☐	Have you ever had prolonged bleeding following extractions?
☐	☐	Have you ever had instruction on the correct method of brushing your teeth?
☐	☐	Have you ever had instructions on the care of your gums?

Comments:____

Patient/Guardian Signature: ____ Date:_____________________________

Witness Signature: ____ Date:____________________________

I attest that I have discussed the risks, benefits, consequences, and alternatives of crowns, bridges and veneers with the patient, who has had the opportunity to ask questions, and I believe my patient understands what has been explained.

Provider Signature: ____ 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, anesthetics, 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 Date

____ ____________________

Patient/Guardian's Signature Date

Santa Ynez Tribal Health Clinic

Notice of Privacy Practices

We are committed to protecting your personal health information in compliance with the Federal law. We may use or disclose your personal health information for these purposes:

For Treatment, Payment, Health Care Operations, Appointment Reminders, Health Related Services and Treatment Alternatives, Fundraising Activities, Individuals Involved in Your Care or Payment for Your Care, Research, Organ and Tissue Donation, As Required By Law, To Avert a Serious Threat to Health or Safety, Military and Veterans, Workers' Compensation, Public Health Activities, Health Oversight Activities, Lawsuits and Disputes, Law Enforcement, Coroners, Health Examiners and Funeral Directors., National Security and Intelligence Activities. Protective Services for the President and Others, and Inmates.

You have certain rights with respect to your personal health information:

Right to Inspect and Request a Copy, Right to Amend, Right to Receive an Accounting of Disclosures, Right to Request Restrictions, Right to Receive Confidential Communications, Right to a Paper Copy of this Notice.

Changes to this Notice:

We reserve the right to change this notice and to make the changed notice effective for all of the health information that we maintain about you, whether it is information that we previously received about you or information we may receive about you in the future. We will have available a copy of our current notice in our facility. Our notice will indicate the effective date on the first page, in the center of page. We will also give you a copy of our current notice upon request.

Complaints:

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. You may file a complaint by mailing us a written description of your complaint or by telling us about your complaint in person or over the telephone:

Ron Sisson, Executive Director
Santa Ynez Tribal Health Clinic
90 Via Juana Lane
Santa Ynez, CA 93460
(805) 688-7070

Santa Ynez Tribal Health Clinic

Acknowledgement of Receipt Privacy Practices Notice and Advance Health Care Directives Information

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:

☐ I have been provided the HIPAA Privacy Act Notice to read.

☐ I have been provided the Patient Rights and Responsibilities Notice to read.

☐ I have been provided the Advance Health Care Directive Information to read.

*****At any time, I may request a copy of any of the above documents 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 (student, 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 assistant 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.

____ ______________

Patient's Signature Date

____ ______________

Signature of Parent or Patient's Representative Date

Santa Ynez Tribal Health Clinic

Late Arrival Acknowledgement Form

If you arrive more than 9 minutes late to your appointment, you will be subject to the following terms:

If you are willing to wait, we will try to work you into an open slot, but this is not a guarantee.

You will also be given the option to wait on the "Stand-By" appointment list to be seen that same day with a different provider - possible wait times on the "Stand-By" list can be as long as 4 hours.

If you have 3 or more late arrivals in any 6 month period it will be counted as a No Show and be subject to the No Show Policy (available upon request).

I have read and fully understand the Santa Ynez Tribal Health Clinic Late Policy and No Show Policy and agree to follow the policy as written.

____ _______________________________

Patient Name (Print) Date

____

Patient Signature