



# 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		DATE OF BIRTH		SEX		MOTHER'S MAIDEN NAME	
PHYSICAL ADDRESS				BILLING ADDRESS			
CITY	STATE	ZIP	CITY	STATE	ZIP		
HOME PHONE #		CELL PHONE #		E-MAIL ADDRESS		PREFERRED PRONOUNS	
PREFERRED METHOD FOR NOTIFICATIONS (check all that apply) <input type="radio"/> Phone <input type="radio"/> Text <input type="radio"/> E-mail <input type="radio"/> Voice reminders							
MARITAL STATUS <input type="radio"/> Annulled <input type="radio"/> Divorced <input type="radio"/> Domestic Partner <input type="radio"/> Legally Separated <input type="radio"/> Life Partner <input type="radio"/> Married <input type="radio"/> Polygamous <input type="radio"/> Single <input type="radio"/> Unknown <input type="radio"/> Widowed							
RACE <input type="radio"/> American Indian or Alaska Native <input type="radio"/> Asian <input type="radio"/> Black or African American <input type="radio"/> Hispanic or Latino (all races) <input type="radio"/> Native Hawaiian or Other Pacific Islander <input type="radio"/> White <input type="radio"/> Other Race <input type="radio"/> Declined to specify							
ETHNICITY <input type="radio"/> Hispanic or Latino <input type="radio"/> Not Hispanic or Latino <input type="radio"/> Other <input type="radio"/> Unknown <input type="radio"/> Declined to Specify							
PREFERRED LANGUAGE <input type="radio"/> English <input type="radio"/> Spanish <input type="radio"/> Other: _____				VETERAN <input type="radio"/> YES <input type="radio"/> NO			
NATIVE AMERICAN (Tribal Patients Only) Do you have verification of Tribal Membership? <input type="radio"/> Yes <input type="radio"/> No Name of Tribe: _____							

### EMERGENCY CONTACT

NAME	RELATIONSHIP	CONTACT PHONE NUMBER
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### INSURANCE

#### Do you have health insurance and/or Medi-Cal?

☐ Yes ☐ No

#### PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER
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#### SECONDARY INSURANCE (if applicable)

NAME OF INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER
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### 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 text or email. (Standard rates may apply.)

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

Responsible Party's Signature \_\_\_\_\_

Date \_\_\_\_\_

Witness \_\_\_\_\_

Date \_\_\_\_\_



# 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.***

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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 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.

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Patient's Signature

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Date

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Signature of Parent or Patient's Representative

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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 be 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.

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Patient Name (print name)

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Patient/Guardian Signature

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

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

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Do your gums bleed while brushing or flossing?           |
| <input type="checkbox"/> | <input type="checkbox"/> | Are your teeth sensitive to hot or cold liquids/foods?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Are your teeth sensitive to sweet or sour liquids/foods? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you feel pain to any of your teeth?                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any sores or lumps in or near your mouth?    |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had any head, neck or jaw injuries?             |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have frequent headaches?                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you clench or grind your teeth?                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you bite your lips or cheeks frequently?              |
| <input type="checkbox"/> | <input type="checkbox"/> | 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

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had any orthodontic work?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had prolonged bleeding following extractions?                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had instruction on the correct method of brushing your teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | 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.



## Santa Ynez Tribal Health Clinic Cancellation/No Show Policy



The mission of the Santa Ynez Tribal Health Clinic is to provide the highest quality of health care, honoring cultural values and integrating best practices. When any of our scheduled appointments are cancelled by a patient with short notice, when a patient arrives late for their appointment, or when a patient "no shows", there is insufficient time for us to reappoint that time for another patient. Late cancellations/arrivals or "no shows" are a lost opportunity for patients to take advantage of our valued services.

The following guidelines outline our Cancellation/No-Show policy for the SYTHC Behavioral Health/Medical/Dental clinics, effective immediately:

- Cancellations of scheduled appointments should be received by the Front Office, **at least 24-hours prior** to the scheduled appointment time.
  - Exceptions will be considered in the event of an emergency or illness on a case-by-case basis.
  - Any late cancellation (not received 24 hours prior to the appointment time) will be considered a "no-show".
- When a patient arrives more than nine (9) minutes late for their scheduled appointment time, the appointment will be considered a "no-show".
- If a patient does not show up (w/o sufficient or zero notice) for their scheduled appointment, this will be considered a "no-show".
- If a patient has two (2) "no-shows" over a 6-month timeframe for any of our clinical departments, the patient may not be eligible to schedule an appointment in that clinical department for six (6) months, from the date of the second no-show.

Please sign this form, indicating your understanding of our cancellation/no-show policy. Your cooperation is vital to the clinic's ability to offer the highest quality health care to all of our patients.

Sincerely,

*Santa Ynez Tribal Health Clinic Health Board*

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Print Patient Name

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Date

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Patient Signature



## Santa Ynez Tribal Health Clinic Absent Consent Form



In the event you are unable to accompany your child to his/her appointment at SYTHC, please list all persons over the age of 18 that you authorize to make decisions for your child's treatment.

PARENT/GUARDIAN NAME
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PATIENT NAME	PATIENT DATE OF BIRTH
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I hereby appoint,

NAME	RELATIONSHIP	CONTACT NUMBER
NAME	RELATIONSHIP	CONTACT NUMBER
NAME	RELATIONSHIP	CONTACT NUMBER
NAME	RELATIONSHIP	CONTACT NUMBER

I hereby release the Santa Ynez Tribal Health Clinic and it's staff from all harm which may results from treatment. The consent and authorization shall include and extend to all matters for which consent, or authorization is required under the policies of Santa Ynez Tribal Health Clinic. In consideration of the services which are rendered to my child, we agree to pay for all services provided.

Please note: if there is a custody dispute involving the child, please be advised that unless a court order is submitted to SYTHC, both parents will have rights to the child's healthcare records. ALL persons listed on this form must present a photo identification when accompanying the child to the appointment. This permission shall remain in effect until such time as I issue a written revocation.

PARENT SIGNATURE	DATE
WITNESS SIGNATURE	DATE