Welcome to Keystone Dental Care!

We are honored you have chosen us to provide your dental treatment. We pride ourselves in offering comprehensive dental care. Please have the items listed below prepared to bring with you for your first dental visit.

- **Medical history -** including lists of surgeries, medications and supplements
- **Dental x-rays –** Please contact your previous dental care provider and bring any recent x-rays with you including your last full mouth series and/or panorex x-ray. Please note that a full mouth series and/or panorex is typically taken every 5 years. To have your records transferred to our office, see attached form.

Your first appointment will consist of information gathering to establish you as our patient and to diagnose your dental needs. Each patient's needs and appointment is unique. The circumstances surrounding this first encounter with us may factor into whether all preventative services will be completed in one visit, or if additional visits are required.

Your first appointment may require more than one visit depending on the following:

- The condition of your teeth and gums
- Your need for x-rays
- An initial appointment normally takes longer than future exams as it includes a comprehensive health history, dental x-rays, periodontal evaluation, and charting existing dental work. We will also be working with you towards developing a treatment plan that best suits your dental needs and goals.

We look forward to meeting you!

KEYSTONE HEALTH CENTER

AUTHORIZATION FOR RELEASE OF MEDICAL/ DENTAL RECORD INFORMATION

Patient Name: ____________________ **DOB**: ____________________ Gender ☐ M ☐F

Address: ____________________ **Phone :** ____________________

____

PERSON OR ENTITY AUTHORIZED TO RELEASE INFORMATION:

____

Address: ____________________**Phone:** ____________________

____________________**Fax:** ____________________

PERSON OR ENTITY AUTHORIZED TO RECEIVE INFORMATION:

____

Address: ____________________**Phone:** ____________________

____________________**Fax:** ____________________

Information to be Released/Received: ☐ **Electronic Medical Record** (last 3 years) ☐ **Dental Record** (may be charged fee for x-ray copies)

OR/ Specific Service Dates: From:____________________ To: ____________________ to include the following:

Specific information Requested: ____________________

____

____

____

Medical Copy Includes: patient chart summary *(which includes)*, medications, allergies, immunizations and chronic problems. Office notes, lab and testing results, inpatient and outpatient consult notes and records from previous physicians. A **Medical Copy** may include information from Keystone Family Medicine, Keystone Audiology and Speech, Keystone Internal Medicine, Keystone Women's Care, Keystone Pediatrics, HIV, Keystone Behavioral Health, Keystone Family Planning/Outreach, Crisis, Keystone Urgent Care, Keystone Infectious Disease and Keystone Dental * ***Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules*.***

Format: ☐ **Electronic Media/USB** (one copy at no charge) ☐ **Paper** (KHC fee charged)

Special Records: I understand documentation regarding my diagnosis or treatment for, psychiatric care, drug/alcohol, AIDS/HIV, sexual abuse/assault and reproductive health, may be released as part of my health information, ***(unless the specific boxes below are checked indicating to exclude this information. Indicating exclusion reduces the amount of information that can be released and potentially places you at risk...)***

AIDS/HIV Information	Psychiatric Care/Treatment	Drug/Alcohol Treatment	Sexual Abuse/Assault Counseling & Reproductive Health
☐ No, do not disclose	☐ No, do not disclose	☐ No, do not disclose	☐ No, do not disclose

X Patient initials ____________________ **(initials must be present to release)**

Purpose of Request: ☐ Verbal Exchange ☐ Continuity of care ☐ Transfer of care ☐ Legal Reason____________________
☐ Moving ☐ Unhappy with care ☐ Insurance Reason ☐ Personal use ☐ Other____________________

Authorization: I hereby authorize Keystone Health Center to disclose/obtain the health information described above. *I understand I may revoke this authorization at any time by notifying the Facility's Privacy Officer in writing of my revocation. *I understand that revocation will not have any effect on actions the Practice took before the revocation. This authorization is voluntary.* I understand that my treatment or payment for services will not be effected if I do not sign this authorization.
I understand that if this organization authorized to receive the information is not a health plan or a health care provider, the information may no longer be protected by federal privacy regulations. I understand once I take possession of the requested copy, it is then my responsibility to safeguard the Protected Health Information.

*This Authorization will expire: ☐ ____/_____/______ ☐ Event ____________________ ☐ One Year, unless otherwise specified.
☐ This authorization will expire 90 days after the date of this request.

____________________ ____________________
Signature of patient or personal representative (Patient 14 years of age or older must sign) Date

____________________ ____________________
Relationship to personal representative of patient Date

____________________ ____________________
Signature of Parent (or legal guardian) Date

Staff Initials____________________ Date ____________________

PATIENT REGISTRATION

Patient Information

Name: ____
First Middle Last

Address: ____

Social Security Number: ____________________ Home phone: (____)____________ Cell Phone: (____)____________

Date of Birth: ______________ Marital Status: _________ Gender: ◯ M ◯ F

Race: ◯ American Indian/Alaska Native ◯ Asian ◯ Black ◯ White ◯ Native Hawaiian ◯ Other Pacific Islander

Ethnicity: ◯ Hispanic or Latino ◯ Not Hispanic or Latino

Do you have medical insurance? ◯ Yes ◯ No

If you do not have insurance, would you like to get information about our reduced fee program? ◯ Yes ◯ No

Are you a US veteran? ◯ Yes ◯ No Are you homeless? ◯ Yes ◯ No

Parent's Information

(Complete this section for a patient less than 18 years old)

Mother's Name: ____ Date of Birth:_______/_________/_______
First Middle Last

Father's Name: ____ Date of Birth:_______/_______/_______
First Middle Last

Is there a Legal Child Custody Agreement? ◯ Yes ◯ No

(If yes, are there any legal restrictions that would prevent the non-custodial parent from consenting to medical/dental treatment for the child or from obtaining information about the child's medical/dental treatment?) ◯ Yes ◯ No

*****Please provide proof of parental custody orders or other legal agreements*****

Emergency Contact Person

Name:____/__________________
First Middle Last Relationship to patient

____/__________________
Address Phone

Person Responsible for Payment

(Complete this section for a patient less than 18 years old)

Name:____/__________________
First Middle Last Relationship to patient

Social Security Number: ________________________ Date of Birth: ________________________

Address: ____

Home phone: ______________________ Cell phone: ____________________

I agree that the above information is correct and accurate to the best of my knowledge. I also understand that any charge(s) not covered by my insurance(s) will be my responsibility.

Signature: ______________________________ Date: ____________________

For Office Use Chart #: Insurance scanned: yes/no Date: Initials:

1/2/19 ksw

PATIENT LEARNING ASSESSMENT

As part of Keystone Health, we strive to meet the diverse needs of our patients. Please complete the following questionnaire to assist us in making every attempt to meet your learning needs. Please let us know if you need help in completing this form. Thank you.

1. Are you able to read? ☐ Yes ☐ No
2. Are you able to write? ☐Yes ☐No
3. Do you want to learn about your health needs? ☐ Yes ☐ No
4. Please indicate level of education (last grade of school completed) _____________
5. Please indicate your dominant language. ☐English ☐ Spanish
   ☐Other_________________
6. Do you need a translator? ☐ Yes ☐No
7. Do you use a hearing aid? ☐ Yes ☐ No
8. Do you use other device(s) to aid in communication? ☐ Yes ☐ No
   If yes, please explain____
   ____
9. Please indicate any possible barriers to education: ☐ None ☐ Cultural
   ☐Emotional ☐Religious ☐Physical Limitations ☐ Visual/Hearing Limitations
   ☐ Limited Learning Ability ☐Learning Deficit
   If any barriers checked, please specify_____________________________________
   ____
10. Please check preferred learning style(s). Please check all that apply.
    ☐ Reading a handout or pamphlet
    ☐Watching a demonstration then doing task
    ☐ Listening to someone provide explanation on the topic
    ☐ Watching the topic on tape

Patient's Name ______________________ Date of Birth ___________________

Patient's Signature ____

If patient is unable to sign, name of person completing form________________

Relationship to patient____

Staff Initials________________ Date ________________________

PATIENT LEARNING ASSESSMENT

PERMISSION TO SHARE PROTECTED
HEALTH INFORMATION

Patient's Full Name: ____
(First) (Middle) (Last)

Patient's Date of Birth: ________/___________/__________Telephone:________________________

Keystone Health shares one electronic record. Any person(s) you authorize will have access to your financial/medical/dental and behavioral health information.

Name: ___________________________________Relationship to Patient: _______________________

Name: ___________________________________Relationship to Patient: _______________________

Name: ___________________________________Relationship to Patient: _______________________

Keystone Health uses a reminder system and/or patient portal to communicate with our patients. Please complete the information below, so that we may keep in touch with you regarding your health.

Cell Phone:____(you will receive a text message)

E-mail:____ (you will receive an email)

By signing, I give permission to Keystone Health to share my protected health information to the individuals listed. This permission remains in effect until revoked in writing.

____ __________________________

Signature of Patient or Authorized Representative Date
(Patients 14 years and older must sign if consenting for treatment on own behalf)

____
Staff Initials

Patient Name ______________________________ Date of Birth __________________ Chart # ____________
Last First Middle

Do you have or have you had any of the following?
(Check all that apply)

______ High Blood Pressure
______ Heart Attack, when?________
______ Cardiac Pacemaker
______ Stroke
______ Heart Trouble
______ Mitral Valve Prolapse
______ Rheumatic Fever
______ Heart Disease
______ Heart Murmur
______ Hepatitis (type)_____
______ Angina
______ Chest Pains
______ Low Blood Pressure
______ Asthma
______ Diabetes
______ Emphysema
______ Anemia
______ Tuberculosis
______ Thyroid Problem
______ Arthritis
______ Liver Disease
______ Respiratory Problems
______ Leukemia
______ Epilepsy/Convulsions
______ Fainting/Seizures
______ Joint Replacement
______ Stomach Troubles/Ulcers
______ Recent Weight Loss
______ Glaucoma
______ Radiation Therapy
______ Alcohol use Problem
______ Drug Use Problem
______ Cancer (type) ______
______ Frequently Tired
______ AIDS or HIV Infection
______ Kidney Diseases
______ Swollen Ankles
______ Sexually Transmitted Disease
______ Hay Fever/Allergies
______ Easily Winded

Current Medications: (please list)

Medication name	Dosage	# per day

Health related substances
(Vitamins, herbal or natural products)

Medication name	Dosage	# per day

Allergies and Reactions (Check all that apply)

	Allergy	Reaction
______	Local Anesthetic (Novocaine)	
______	Penicillin or other Antibiotics	
______	Sulfa Drugs	
______	Prescription Pain Medications	
______	Tylenol, Aspirin or Ibuprofen	
______	Metals (nickel, mercury, etc)	
______	Latex Rubber	

List Others:
______________________ ______________________
______________________ ______________________
______________________ ______________________

Additional Health History

Medical Physician____________________ Last Med. Exam?____________
Address ____________________________ Phone # ( )________________

1. Have you ever taken Fosamax, Zometa, Aredia or Boniva or any other medications for Osteoporosis (bone loss)? Yes No
2. Are you under medical treatment now? Yes No
   If yes, please list____
3. Have you ever had a serious illness/major surgery? Yes No
   If yes, please list____
4. Do you use tobacco?(circle) smoke chew snuff electronic/vap Yes No
5. Have you been diagnosed with any psychiatric or anxiety disorders? Yes No
6. Have you been diagnosed with a physical disability? Yes No
   If yes, please explain______________________________________
7. Women Only:
   Are you pregnant or think you may be? Yes No
   Are you nursing? Yes No
   Are you taking oral contraceptives? Yes No

Office Use Only:

I Certify that the above information is complete and accurate.

Patient/Guardian Signature ______________________________ Date:________ Dentist Signature__________________ Date:_________

 Please Complete the back page also (turn over)

Patient Name ______________________________ Date of Birth _____________ Chart # __________

DENTAL HISTORY

Name of Previous Dentist and Location ____________________________Date of last Exam ______________

1. Purpose of initial visit__________________________________
2. Are you aware of a problem?____________________________
3. How long since your last dental visit?_____________________
4. What was done at that time?____________________________
5. When were your teeth last cleaned?______________________
6. Have you made regular visits? Yes No
7. Were Dental X-rays taken? Yes No
8. Do you have missing teeth? Yes No
9. How have they been replaced?___________________________
10. Are you happy with the replacement? Yes No
11. Have you had any problems with previous dental treatment?____
12. Do you clench or grind you teeth? Yes No
13. Does your jaw click or pop? Yes No
14. Do you have pain or soreness in the muscles of your face or around your ear? Yes No
15. Do you have frequent headaches, neck aches or shoulder aches? Yes No
16. Does food get caught in your teeth? Yes No
17. Are any of your teeth sensitive to: Circle below
    Hot Cold Sweets Pressure
18. Do your gums bleed or hurt? Yes No
19. Do you experience dry mouth? Yes No
20. How often do you brush your teeth & when?_______________
21. Do you use dental floss? Yes No
22. Are any of your teeth loose, tipped, shifted? or chipped? Yes No
23. Are you unhappy with the appearance of your teeth? Yes No
24. How do you feel about your teeth?______________________
25. Do you feel your breath is offensive at times? Yes No
26. Have you ever had gum treatment or surgery? Yes No
27. Have you had any orthodontic work? Yes No
28. Have you had any unpleasant dental experiences or is there anything about dentistry you strongly dislike?

____

29. Do you have any questions or concerns? Yes No

____

Office Use only:

Patient/Guardian Signature __________________________ Date: ____________________

Dentist Signature _________________________________ Date: ____________________

PERMISSION FOR TREATMENT OF
CHILDREN

Patient's Full Name: ____

(First) (Middle) (Last)

Patient's Date of Birth: ______/________/___________

Name of Parent/Legal Guardian: ____

If I can't bring my child to a medical/behavioral health or dental appointment, I give permission for the person(s) listed below to go with my child to visits at Keystone Health Center. He/she can also approve treatment for my child during the visit, including shots and minor dental and medical procedures.

Name: ___________________________________Relationship to Patient: ______________________

Name: ___________________________________Relationship to Patient: ______________________

Name: ___________________________________Relationship to Patient: ______________________

Please Note: Sometimes, the provider may decide that a parent must be present for certain dental procedures: extractions, root canals, surgical procedures, nitrous visits and operating room visits.

This permission remains in effect until revoked in writing.

______________________________________ ______________________________
Parent/Guardian Signature Date

____ ______________________________
Witness Signature Date

____
Staff Initials

2./14/19 ksw

As a Community Health Center, our mission is to take care of people no matter what their race, ethnicity or income. This survey will help us know if we are helping all kinds of families within our community. Please fill in the information below to best tell us about you and your family.

Race- relates to a persons appearance such as skin color:
□ **White/Caucasian** □ **Black/African American** □ **Asian** □ **American Indian**
□ **Native Hawaiian** □ **Other Pacific Islander** □ **Multi-racial**

Ethnicity- relates to nationality and culture:
□ **Latino/Hispanic** □ **Non Latino**

Do you live in public housing:
□ **Yes** □ **No**

Family Size	Annual Family Income			
1	☐$12,490 and below	☐$12,491 to $18,735	☐$18,736 to $24,980	☐$24,981 and above
2	☐$16,910 and below	☐$16,911 to $25,365	☐$25,366 to $33,820	☐$33,821 and above
3	☐$21,330 and below	☐$21,331 to $31,995	☐$31,996 to $42,660	☐$42,661 and above
4	☐$25,750 and below	☐$25,751 to $38,625	☐$38,626 to $51,500	☐$51,501 and above
5	☐$30,170 and below	☐$30,171 to $45,255	☐$45,256 to $60,340	☐$60,341 and above
6	☐$34,590 and below	☐$34,591 to $51,885	☐$51,886 to $69,180	☐$69,181 and above
7	☐$39,010 and below	☐$39,011 to $58,515	☐$58,516 to $78,020	☐$78,021 and above
8	☐$43,430 and below	☐$43,431 to $65,145	☐$65,146 to $86,860	☐$86,861 and above
9	☐$47,850 and below	☐$47,851 to $71,775	☐$71,776 to $95,700	☐$95,701 and above
10	☐$52,270 and below	☐$52,271 to $78,405	☐$78,406 to $104,540	☐$104,541 and above

Revised 3.13.19

****NOTICE TO ALL PATIENTS and PARENTS****

Keystone Dental Care now requires that only one (1) person be allowed in the treatment area with the patient being seen for the appointment. We give utmost importance to the safety and security of our patients and their families. Allowing more than one (1) person in the treatment area affects those safety measures.

Parents & Patients

1. When a child is being seen, other children will not be allowed in the treatment area. Children under the age of 13 or special needs persons are not to be left in the waiting room without a parent or guardian present.

2. Adults - If you are the patient with the appointment, we can not allow unattended young children or special needs persons in the treatment area who may require supervision.

Our employees are not able to baby-sit or take care of your children while you are receiving treatment. When scheduling your appointment please keep in mind that you will need to arrange child care or bring another adult to attend your child in the waiting area.

3. A Parent or legal guardian must be present at the first visit or any consent required visits, such as Root Canal or Extraction. A Keystone Parental Permission form must be signed and dated for any other adult to bring your children to basic services visits (exam, cleanings, fluoride, x-rays, fillings and sealants).

4. All minor children under the age of 18 must have a parent, guardian or approved adult in the office during the entire treatment time. If the adult leaves the office the treatment will be rescheduled.

5. Failure to comply with these policies may result in our not being able to see you for your appointment.

Patient Name (Please Print) ______________________________ Date:___________
Patient/Parent/Guardian Signature: _______________________ Date: ___________

Helpful Tips to make your child's first trip to the Dentist A great one!

Your child's first dental appointment to our office will likely influence how he or she will feel about dental treatment for the remainder of his or her life. Before your child is seen for their first appointment, we would like to share a few tips to help this experience be a success!

The goal is to avoid associating dental visits with something to be afraid of.

Parents can do several things to prepare children for their first visit to our dental office. Simulating office visits at home is one way to get children used to visiting the dentist. You can lay them on a bed, couch, etc. and use a flashlight to look around and count each tooth with a toothbrush, the child could even hold a mirror so they can see what you are doing.

When you talk with your child you can encourage them by using child friendly words. This may help them to be more at ease. Here's a guide to what can be used to prepare for each type of visit.

Hygiene visit:
"Count your teeth" instead of exam or examination
"Tickle your teeth" instead of tooth cleaning or scraping
"Tooth Counter" instead of explorer or poke your teeth
"Take pictures" instead of x-rays

Restorative/Filling visit:
"Sleepy Juice" instead of shot, needle or injection
"Mr. Whistle" instead of drill
"Clean your tooth" instead of drill on your tooth
"Nap time or Sleepy time" instead of numb
"Wiggle a tooth out" instead of extraction, pull or yank
"Mister Thirsty" instead of suction

Tell them you get to sit in a cool movable chair and go for a ride. They may even get to wear sunglasses so that the dental flashlight "Mr. Sun" doesn't get in their eyes. They will get a new toothbrush during a visit with the hygienist. It may be beneficial to make arrangements for siblings to be cared for by family members while you bring your son/daughter exclusively to their appointment time. This will allow your child to have your complete attention and support during their dental procedures. This will give them encouragement and comfort.

** Our office requests for you to arrive thirty minutes before your appointment, giving you the parent{s} ample time to complete paper work, not feel rushed or anxious and for your child to become familiar with our office. Make your child's first dentist appointment about them.**