COMMUNITY DENTAL CLINIC

3428 Armour, Fort Smith AR 72904

Phone: 479-782-6021 Fax: 479-709-0161

Do Not Mail In Application

Check ☑	**To be a patient you must be able to check all the boxes & meet income guidelines: We will give application back to you if these items are not with the application.**
	You must live in Crawford or Sebastian County. **Include 1 Utility Bill with YOUR physical Address. Letters from shelter are ACCEPTED.**
	Copy of **Picture ID for the patient and Each Family member over 18.**
	Copy of **Social Security Cards for all the people in the household.**
	I certify I do not have **Dental Insurance** or **Dental Covered Medicaid.**
	For anyone working: copies of 5 recent **check stubs** this applies to anyone working in the home regardless if they're related or not.
	For anyone not working or that receives a benefit including children: Must have a **letter from Social Security stating you receive, applied or do not have social security. This may be obtained at the Social Security Office.** If separated or divorced **A letter from child support stating you do or do not have a case filed.** All person over 18 with no income – must have a **Work History Screen Printout** from the Unemployment Office.

Circle # in Household	Yearly Income Limit
1	$11,100
2	$12,700
3	$14,300
4	$15,850
5	$17,150
6	$18,400
7	$19,700
8	$20,950

8:00 – 4:30 M-T Closed for lunch each day.

Application may be turned in on Mondays.

Confidentiality Statement

Information shared with CSCDC staff will be **strictly** confidential. These forms will be maintained in locked files.

INTAKE/FAMILY PROFILE PLEASE PRINT

PATIENT PERSONAL INFORMATION: ARE YOU HEAD OF HOUSEHOLD :YES:____ NO:____

Your Name:____ Your SS#_____-____-________

YOUR DATE OF BIRTH:_____/_____/________ AGE:________ SEX: MALE: ________ FEMALE: ________

ADDRESS:______________________________ CITY:______________ ZIP: ____________

HOME PHONE:(_____)__________ CELL PHONE: (_____)__________ Carrier:______________

Race: African American:___ Asian:___ Hispanic: ___ Native American: ___ White:______

Multi Race: ___ Other: ____ Primary Language: ENGLISH:___ SPANISH:___ OTHER:____

TYPE OF HOUSEHOLD:

ARE YOU SINGLE: ______ MARRIED:________ SEPERATED:_________DIVORCED:__________
WIDOWED:__________

ARE YOU A: SINGLE PARENT_______ 2 PARENT HOUSEHOLD_______ DIVORCED With CHILDREN_______
HOMELESS:_________ OTHER:_____

DO YOU OWN:____ RENT:____ SHELTER/TREATMENT:______ HOMELESS:_____ OTHER:______

ARE YOU A FARMER: YES:_____ NO:________ SEASONAL FARMER:_______

TYPE OF INCOME:

ARE YOU WORKING:_____ NON-WORKING:______ RECEIVE BENEFIT:_____TYPE OF BENEFIT: SSA ___
SSI___ SSD___ VA___PENSION___

DO YOU RECEIVE FOOD STAMPS:____ TEA:______ HUD:______ GENERAL ASSISTANCE:______

YOUR Income amount:$______________ PER WEEK:____ BI WEEKLY:___ MONTHLY:_____

Total for the year: $______________ No Income: ______

Are YOU Veteran: YES:____ NO: ____ ARE YOU Disabled: YES:___
NO:______

DO YOU HAVE Health Insurance: YES____ NO_____ TYPE OF INSURANCE:______________

Your Education level:

Education: 0-8:___ 9-12:___ GRADUATE:____GED:___ 12+ Some Post-Secondary ___
2 or 4 years college ___

Patient Health History PLEASE PRINT

Patient Name: ______________________________ Birth date: ______/______/______

	YES	NO		YES	NO
Are you in good health?			Have you had abnormal bleeding?		
Are you under a Doctor's care?			Problems when teeth pulled?		
Date of last physical exam:			Have you ever had a blood transfusion?		
Name of Primary Doctor:			Have you had a recent weight loss without cause?		
Phone # of Doctor:			Do you use tobacco products? If so, what type:		
NOTE: If you have heart problems, joint replacement, or are pregnant we will need a note from your doctor concerning treatment.			Have you used controlled substances? Chemical Dependency?		
Have you been hospitalized for a serious illness or operation?	Yes	No	Do you drink alcohol?		
Are you taking any medications?			Do you have a persistent cough or throat clearing not due to a known illness?		
If yes, what medications do you take: ____			**If you are female:**	YES	NO
			Are you pregnant?		
			Due Date:		
			Are you nursing?		
Do you take a blood thinner? If yes, which one?			**What is your dental need:**		

HEALTH INFORMATION & ALLERGIES

ALLERGY OR REACTION TO:	YES	NO	**HEALTH HISTORY continued**	YES	NO
Local anesthetics like Novocain			**Diabetes**		
Penicillin			Eating Disorder		
Sulfa Drugs			Enlarged Lymph glands		
Pain medications (**Lorcet, Lortab, codeine**)			Epilepsy or Seizures		
Aspirin			Gastric Bypass		
Tylenol/Ibuprofen			**Heart Trouble:** Heart Attack, Angina, Chest Pain		
Any metals (i.e. nickel, mercury, etc.)			Heart Surgery: **Pacemaker, Bypass, etc.**		

Health problems that you may have or medications that you may be taking could have an important effect on your dental care. Thank you for answering the following questions so that we may provide better dental care to you.

Patient **Health History**

	YES	NO
Latex/Rubber		
Other? Please List: medicines you are allergic to:		
	YES	NO
Foods		
If yes, please list:		
HEALTH HISTORY	YES	NO
Acid Reflux		
AIDS or HIV Infection		
Anemia		
Arthritis		
Asthma or Breathing Problems		
Autoimmune Disorder – (Lupus, Rheumatoid Arthritis)		
Cancer -		
Cortisone Treatment		

	YES	NO
Mitral Valve Prolapse		
Heart Defect or Heart Murmur		
Hepatitis		
High Blood pressure		
Hives or skin rash		
Hypoglycemia (low blood sugar)		
Joint/Bone replacement or implant		
Kidney Dialysis, Transplant, or Disease		
Nervous Disorders/Depression		
Pancreatitis		
PTSD		
Rheumatic Heart Disease/Rheumatic Fever		
Scarlet Fever		
Shortness of Breath		
Stomach ulcer		
Stroke		
Swelling of feet, ankles, hands		
Thyroid Problems		
Tuberculosis		
Tumors, radiation, chemotherapy		

Health problems that you may have or medications that you may be taking could have an important effect on your dental care. Thank you for answering the following questions so that we may provide better dental care to you.

HH member #2 Relationship to PATIENT: ______________________ SOCIAL SECURITY: ______________

Name: ______________________ DATE OF BIRTH: ___/___/_____ SEX: MALE: _____ FEMALE: _____

ARE YOU SINGLE: ______ MARRIED: _________ SEPERATED: _________ DIVORCED: ___________
WIDOWED: ____________

Race: African American: ___ Asian: ___ Hispanic: ___ Native American: ___ White: ______
Multi Race: ___ Other: ____ Primary Language: ENGLISH: ___ SPANISH: ___ OTHER: ____

TYPE OF INCOME:

ARE YOU WORKING: _____ NON-WORKING: ______ RECEIVE BENEFIT: _____ TYPE OF BENEFIT: SSA ___
SSI ___ SSD ___ VA ___ PENSION ___

DO YOU RECEIVE FOOD STAMPS: ____ TEA: ______ HUD: ______ GENERAL ASSISTANCE: ______

YOUR Income amount: $ _______________ PER WEEK: ____ BI WEEKLY: ___ MONTHLY: _____

Total for the year: $ _______________ No Income: ______

Are YOU Veteran: YES: _____ NO: _____ ARE YOU Disabled: YES: ___ NO: ______

DO YOU HAVE Health Insurance: YES ____ NO _____ TYPE OF INSURANCE: _______________

Your Education level:

Education: 0-8: ___ 9-12: ___ GRADUATE: ___ GED: ___ 12+ Some Post-Secondary ___
2 or 4 years college ___

HH member #3 Relationship to PATIENT: ______________________ SOCIAL SECURITY: ______________

Name: ______________________ DATE OF BIRTH: ___/___/_____ SEX: MALE: _____ FEMALE: _____

ARE YOU SINGLE: ______ MARRIED: _________ SEPERATED: _________ DIVORCED: ___________
WIDOWED: ____________

Race: African American: ___ Asian: ___ Hispanic: ___ Native American: ___ White: ______
Multi Race: ___ Other: ____ Primary Language: ENGLISH: ___ SPANISH: ___ OTHER: ____

TYPE OF INCOME:

ARE YOU WORKING: _____ NON-WORKING: ______ RECEIVE BENEFIT: _____ TYPE OF BENEFIT: SSA ___
SSI ___ SSD ___ VA ___ PENSION ___

DO YOU RECEIVE FOOD STAMPS: ____ TEA: ______ HUD: ______ GENERAL ASSISTANCE: ______

YOUR Income amount: $ _______________ PER WEEK: ____ BI WEEKLY: ___ MONTHLY: _____

Total for the year: $ _______________ No Income: ______

Are YOU Veteran: YES: _____ NO: _____ ARE YOU Disabled: YES: ___ NO: ______

DO YOU HAVE Health Insurance: YES ____ NO _____ TYPE OF INSURANCE: _______________

Your Education level:

Education: 0-8: ___ 9-12: ___ GRADUATE: ___ GED: ___ 12+ Some Post-Secondary ___
2 or 4 years college ___

HH member #4 Relationship to PATIENT: ______________________ SOCIAL SECURITY: ______________

Name: ______________________________ DATE OF BIRTH: ___/___/_____ SEX: MALE: _____ FEMALE: _____

ARE YOU SINGLE: ______ MARRIED: _________ SEPERATED: __________ DIVORCED: ___________
WIDOWED: _____________

Race: African American: ___ Asian: ___ Hispanic: ___ Native American: ___ White: _______
Multi Race: ___ Other: ____ Primary Language: ENGLISH: ___ SPANISH: ___ OTHER: _____

TYPE OF INCOME:

ARE YOU WORKING: _____ NON-WORKING: ______ RECEIVE BENEFIT: _____ TYPE OF BENEFIT: SSA ___
SSI___ SSD___ VA___ PENSION___

DO YOU RECEIVE FOOD STAMPS: ____ TEA: ______ HUD: ______ GENERAL ASSISTANCE: _______

YOUR Income amount: $_______________ PER WEEK: _____ BI WEEKLY: ___ MONTHLY: ______

Total for the year: $_______________ No Income: _______

Are YOU Veteran: YES: _____ NO: _____ ARE YOU Disabled: YES: ___ NO: _______

DO YOU HAVE Health Insurance: YES ____ NO _____ TYPE OF INSURANCE: _______________

Your Education level:

Education: 0-8: ___ 9-12: ___ GRADUATE: ____ GED: ___ 12+ Some Post-Secondary ___
2 or 4 years college ___

HH member #5 Relationship to PATIENT: ______________________ SOCIAL SECURITY: ______________

Name: ______________________________ DATE OF BIRTH: ___/___/_____ SEX: MALE: _____ FEMALE: _____

ARE YOU SINGLE: ______ MARRIED: _________ SEPERATED: __________ DIVORCED: ___________
WIDOWED: _____________

Race: African American: ___ Asian: ___ Hispanic: ___ Native American: ___ White: _______
Multi Race: ___ Other: ____ Primary Language: ENGLISH: ___ SPANISH: ___ OTHER: _____

TYPE OF INCOME:

ARE YOU WORKING: _____ NON-WORKING: ______ RECEIVE BENEFIT: _____ TYPE OF BENEFIT: SSA ___
SSI___ SSD___ VA___ PENSION___

DO YOU RECEIVE FOOD STAMPS: ____ TEA: ______ HUD: ______ GENERAL ASSISTANCE: _______

YOUR Income amount: $_______________ PER WEEK: _____ BI WEEKLY: ___ MONTHLY: ______

Total for the year: $_______________ No Income: _______

Are YOU Veteran: YES: _____ NO: _____ ARE YOU Disabled: YES: ___ NO: _______

DO YOU HAVE Health Insurance: YES ____ NO _____ TYPE OF INSURANCE: _______________

Your Education level:

Education: 0-8: ___ 9-12: ___ GRADUATE: ____ GED: ___ 12+ Some Post-Secondary ___
2 or 4 years college ___

Patient HIPPA CONSENT FORM

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

*a basis for planning my care and treatment.
*a means of communication among the many health professionals who contribute to my care.
*a source of information for applying my diagnosis and surgical information to my bill.
*a means by which a third-party payer can verify that services billed we actually provided.
*and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been told that I can request the Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices, and prior to implementation will mail a copy of any revised notices to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restriction requested. I understand that I may revoke this consent in writing, reliance to the extent that the organization has already taken action in reliance there on.

Signed the ________ day of __________ 20______.

PRINTED PATIENT NAME: ______________________________________

SIGNATURE:____

❖ **I understand that the health care professionals who are licensed under the laws of the State of Arkansas and who render medical services voluntarily and without compensation to any person at any free or low-cost medical clinic located in the State of Arkansas and registered by the State Board of Health, which accepts no insurance payments and provides medical services free of charge to persons unable to pay or provides medical services for a nominal fee, shall not be liable for any civil damages for any act or omission resulting from the rendering of such medical services, unless such an act or omission was the result of such licensee's gross negligence or willful misconduct.**

- ✓ **I understand it is my responsibility to carry out any instructions for follow-up care recommended by the dentist. I also understand that volunteer dentists provide the dental work, and services at the dental clinic are limited to availability of a dentist.**
- ❖ **I give permission for my photographs to be used by the Community Dental Clinic staff by the media, publicity, grants, to be kept on file, and to be on display.**
- ✓ **I hereby grant authority to the Community Dental Clinic and those in charge of my care to administer any treatment and to perform such operations as may be deemed necessary in the treatment of my dental needs.**
- ❖ **The information on this application is true to the best of my knowledge and belief. I understand this form is signed subject to penalties for perjury.**
- ✓ **We have a limited denture program with a FIVE TO SIX YEAR WAIT. DENTURES ARE ONLY AVAILABLE WHEN WE HAVE FUNDING & DENTISTS. Only the Dentist decides if you need dentures then the staff places your name on a waiting list.**

This office complies with Equal Opportunity & Affirmative Action practices. Our services are without regard to race, color, national origin, religion, sex, disability, familial status, or age. Please sign and date to signify that you are aware the Privacy Policy is posted at the Community Dental Clinic.

I hereby state that a copy of the Community Dental Clinic Privacy Policy is posted and I agree to the terms listed in the policy.

Patient Signature: ______________________________ **Date:** ____________

STAFF WITNESS: ____________

DENTURE / PARTIAL PROGRAM CONTRACT

PLEASE READ AND INITIAL EACH LINE AND SIGN AFTER READING

Patient Name: ______________________________ **Date:** _________________________

1. The partials/dentures are $600.00 for a complete set. Denture's for low income patients are available with Dentist approval only. Community Dental will provided a denture/partial for the patient at no charge when and only funding is available, and the patient meets all requirements. __________

2. The partials/dentures you receive from the Community Dental Clinic will last about 4-6 years with careful use & care by you the patient. You will need to consider how you will replace this partial/denture in the future. __________

3. You will receive one set of partials/dentures from the Community Dental Clinic. The clinic will not be responsible for lost, stolen, or negligence (example dog ate) you will be responsible for total replacement of your denture/partials. __________

4. Only the dentist will determine if the partial/denture is defective and therefore covered by the Community Dental Clinic. _________

5. Patient receiving partials will need to continue to have their remaining teeth cleaned every six months. The Community Dental Clinic will not provide cleaning every 6 months. You will need to have a plan in place for these cleanings. ___________

6. Going from natural teeth to a denture/partial is a big adjustment for any patient. The ability to chew food decreases about 90%. Taste of food and often speech may be altered at first.
   CDC will do everything in our power to help you adjust to your new dentures, however, the patient must realize that dentures are a satisfactory replacement for having no teeth at all but they rarely function as well as natural teeth. __________

Consent: I have read the information above and have had a chance to review and discuss my planned treatment. I understand that there is no warranty or guarantee as to any result and understand I can ask for a full recital of any and all possible risks concerning my care by asking.
____

Signature: ____ **Date:** ____________________

Witness: ____ **Date:** ____________________

CONSENT FOR EXTRACTION OF TEETH

Extraction of teeth is an irreversible process and, whether routine or difficult, is a surgical procedure. As in any surgery there are some risks. They include, but are not limited to the following:

1. Swelling and/or bruising and discomfort in the surgery area.
2. Stretching of the corners of the mouth resulting in cracking or bruising.
3. Possible infection requiring additional treatment.
4. Dry socket-jaw pain beginning a few days after surgery, usually requiring additional care. It is more common from lower extractions, especially wisdom teeth removal.
5. Possible damage to adjacent teeth, especially those with large fillings or caps.
6. Numbness or altered sensation in the teeth, gums, lip, tongue and chin, due to the closeness of the tooth roots to the nerves (especially wisdom teeth) which can be bruised or damaged. Almost always, sensation returns to normal, but in rare cases, the loss may be permanent.
7. Trismus-limited opening due to the inflammation swelling, most common after wisdom tooth removal. Sometimes it is a result of jaw joint discomfort (TMJ), especially when TMJ disorders already exist.
8. Bleeding-significant bleeding is not common, but persistent oozing can be expected for several hours.
9. Sharp ridges or bone splinters may form later at the edge of the socket. These usually require another surgery to smooth or remove.
10. Incomplete removal of tooth fragments to avoid injury to vital structures such as nerves or sinus, sometimes small root tips may be left in place.
11. Sinus involvement - the roots of upper back teeth are often close to the sinus and sometimes a piece of root can be displaced into the sinus or an opening may occur into the mouth, which may require additional care.
12. Jaw fracture – although quite rare, it is possible in difficult or deeply impacted teeth.
13. Allergic reactions to medications, although careful precautions are taken to obtain patient's history of allergies, certain dietary and medical factors may cause allergic reactions to medications used during tooth extraction.
14. Although rare, resulting malocclusion (incorrect bite) requiring additional care.

I understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reactions during or following treatment, I agree to report them to the doctor or his designated agent as soon as possible.

I realize that no guarantees or assurances have been given by anyone regarding treatment results that may be obtained. I also understand that if I have any questions regarding my treatment, I am to ask the doctor prior to signing this consent.

I hereby acknowledge that I have read the foregoing, have discussed any questions or concerns I may have regarding my proposed treatment.

Teeth to be removed: AS NEEDED

Patient's Signature: ______________________________ **Date:** ______________

Witness: ______________________________ **Date:** ______________

READ and SIGN THIS PAGE –

YOU MUST CALL TO CANCEL YOUR APPOINTMENT. IF YOU NO-CALL OR NO-SHOW, YOU WILL NOT BE SEEN FOR ONE YEAR.

1. Clinics are by appointment only! We are NOT a WALK-IN CLINIC. Rude behavior or cursing the DENTIST or STAFF is not acceptable and YOU will be banned from the Dental Clinic.
2. We DO NOT provide cosmetic dentistry, orthodontics, sedation, or root canals. CROWNS AND FILLINGS ARE PROVIDED at reduced fees. CLEANINGS are provided January – April with limited space. FOR cleanings you may be referred to UAFS Hygiene School.
3. Non- English speaking patients should have a translator with them at all dental appointments.
4. A pregnant patient must have a note from her doctor giving permission for an X-ray and treatment.
5. If you have a serious medical condition that requires you to be under the care of a physician it may be necessary to provide a medical clearance before treatment. If you have had joint replacement or heart problems that require a Pre-med you will need to get that from your doctor before dental treatment. If you take blood thinners you must check with your doctor about how long you must be off blood thinners before & after dental work!
6. We are unable to provide treatment in another facility, such as a nursing home or hospital. The patient must be able to come to the dental clinic, move to a dental chair for treatment, and answer the dentist's questions.
7. We have a limited denture program. DENTURES ARE ONLY AVAILABLE WHEN WE HAVE FUNDING.
8. Every person applying for dental treatment will need their own application.
9. DO NOT BRING CHILDREN TO YOUR DENTAL APPTOINTMENT.
10. This is a DRUG FREE Establishment: Alcohol & drugs are not allowed at the Community Dental Clinic.
11. Do not call the Dentist at home or at their regular office! If you call them at their regular office you will pay the rates they charge at their office. Calling the Dentist at home will cause you to be BANNED from the Community Dental Clinic.
12. Make sure to take all daily medications as you normally would, except in the case that your doctor or dentist has given you specific instructions not to.
13. NO pets are allowed in the building. DO NOT BRING YOUR PETS.
14. NO SMOKING IN and OR IN FRONT OF THE DENTAL CLINIC. IF YOUR NAME IS CALLED AND YOU ARE OUTSIDE SMOKING, YOUR DENTAL APPOINTMENT MAY BE RESCHEDULED.

Patient Signature ______________________________ Date: __________________