Dental Clinic
Charlottesville Free Clinic

Patient Name: ______________________ ______________________ ______
Nombre del Paciente — Last Name *Appelido* — First Name *Primer Nombre* — Middle Initial *Segundo Nombre*

Gender: ☐ Male ☐ Female **Family Status:** ☐ Married ☐ Single ☐ Child ☐ Other
Género — *Masculino* — *Femenino* — *Estado Civil* — *Casado/a* — *Soltero/a* — *Niño/a* — *Otro/a*

Birthdate: ___/___/___ **Social Security #:** ____________ **Email:** ________________
Fecha de Nacimiento — *Seguridad Social* — *Dirección Electrónico*

Phone: _____________ _____________ ____ _____________
Teléfono — Home *De Casa* — Work *De Trabajo* — Ext. — Mobile *Celular*

Address: ______________________________ ______________________________
Dirección de Domicilio
__________________________ ________________ ________________
City *Ciudad* — State *Estado* — Zip Code *Código Postal*

***IF PATIENT IS A MINOR*:**
Si el Paciente es Un/a Menor:

Parent/Guardian Name: ______________________ **Phone:** ________________
Nombre del padre/madre/apoderado legal

County of Residence:
Condado de Residencia

☐ City of Charlottesville ☐ Albemarle ☐ Buckingham ☐ Louisa ☐ Greene
☐ Fluvanna ☐ Orange ☐ Nelson ☐ Other __________

Race:
Raza:
☐ White/*Blanco* ☐ Black/*Negro* ☐ Asian/*Asiático*

Ethnicity: ☐ Hispanic/*Latino* ☐ Non-Hispanic

Primary Language:
Primera Lengua

☐ English/*Inglés* ☐ Spanish/*Español* ☐ Other/*Otro* ________________

Patient Name: ____

EMERGENCY CONTACT INFORMATION

INFORMACIÓN DE CONTACTO DE EMERGENCIA

Name: _______________________________ **Relationship to Patient:** ______________________________
Nombre *Relación con el Paciente*

Phone: ____________________________ ____________________________
Teléfono Home/De Casa Mobile/Celular

Pain Location: (Circle all that Apply)

Upper Jaw Right: Front Middle Back	**Lower Jaw Right**: Front Middle Back
Upper Jaw Left: Front Middle Back	**Lower Jaw Left**: Front Middle Back

How did you hear about the Dental Clinic:

¿Cómo fué qué escuchó acerca de la Clinica Dental?

☐1. MJH ER/ *Martha Jefferson Emergencia*
☐2. UVa ER/*Hospital UVa Emergencia*
☐3. Doctor's Office/ *Oficina de un Docto*
☐4. Self/ *Yo Mismo*
☐5. Social Worker/ *Trabajador Social*
☐6. Friend or family/ *Un Amigo o familia*
☐7. IRC/ *Comité de Rescate Internacional*
☐8. Neighborhood Family Health Center (located at/ situado en Preston and Rose Hill Dr) Familares centro de salud del barri
☐9. CFC Med Clinic/ *Clínica Gratis de Medicina*
☐10. Other (TV, Radio, etc.)/*Otra*

Do you have dental insurance?
¿Tiene seguro dental?

☐ Yes/*Sí* ☐ No

Are you a CFC Medical patient?
¿Es usted un paciente de Clínica de salud?

☐ Yes/*Sí* ☐ No

DO YOU HAVE MEDICAID? ________ **Do You Have Medicare?**________

Are you taking any prescription blood thinners? ☐ Yes/*Sí* ☐ No
¿Está ustéd tomando anticoagulantes para la sangre de prescripción médica?

List below any prescription medicines, over the counter drugs, or supplements.

Abajo lista alguna medicina prescripta por un medico, medicinas sin prescripción, or algún suplemento.

Patient Name:____

Where do you go for your medical care?____

Donde ir para su atencion medica?____

Health History: Age:________ Weight:__________lbs.

1. **Have you had, now or been advised of any of the following? Please Check yes or no.**

	Yes	No		Yes	No		Yes	No
Any Heart Condition	☐	☐	Shortness of Breath	☐	☐	Hepatitis	☐	☐
Stroke	☐	☐	Asthma	☐	☐	STD	☐	☐
Blood Thinnners	☐	☐	Emphysema	☐	☐	AIDS/HIV	☐	☐
High Blood Pressure	☐	☐	Tuberculosis	☐	☐	Kidney Disease	☐	☐
Diabetes	☐	☐	Mental disorders	☐	☐	Liver Disease	☐	☐
Cancer	☐	☐	Nervous disorder	☐	☐	Thyroid Gland Disease	☐	☐
Biophosphonates	☐	☐	Seizures	☐	☐	Glaucoma	☐	☐

		Yes	No
2.	Are you allergic to any foods, medications or latex? List________________________	☐	☐
3.	Are you currently taking any medications? List___________________________	☐	☐
4.	Have you been hospitalized during the past 2 years? List____________________	☐	☐
5.	Have you been a physician for any medical conditions? List__________________	☐	☐
6.	Have you had excessive bleeding from cuts, previous medical or dental treatment? ________	☐	☐
7.	Does anyone in your family have a history of bleeding problems or problems involving general anesthesia________________________________	☐	☐
8.	Do you have any joint replacements or past heart surgery?____________________	☐	☐
9.	Do you have any conditions, not listed above, which could be a factor in your treatment? Please explain______________________________	☐	☐
10.	Female patients, are you or might you be pregnant? Are you a nursing mother?__________	☐	☐
11.	Do you have a history of tobacco use? ______________________________	☐	☐
12.	Who is your present physician?___________________________________	☐	☐
13.	Who is your present dentist?____________________________________		

Please explain any yes answers:

Patient Name:____

Family Type

☐ 1. Single Adult Only/*Adulto Soltero/a Solamente*
☐ 2. Single Adult+ DC/ *Adulto Soltero/a + nino/a deendiente*
☐ 3. Married Couple Only/ *Pareja Casada Solamente*
☐ 4. Married Couple + DC/ *Pareja Casada + niño/a dependiente*

Family Size ________

Count yourself, spouse, and dependent children/ *Incluyendo a usted, su esposo/a y niños/as de dependiente*

____

**Dependent Children, under 18 years of age/ Niño/a dependiente menor de 18 años de edad*

Patient's Employment Status (or 1st Parent's)
Esatdo de Empleo del Paciente (o del padre)

☐ Employed/ *Empleado*
  ☐ Full Time (35-40 hours) *Tiempo Completo (35-40 horas)*
  ☐ Part Time (34 or less hours) *Medio Tiempo (34 horas o menos)*
☐ Retired/ Retirado
☐ Unemployed/Desempleado

Spouse's Employment Status (or 2nd Parent's)
Esatdo de Empleo de la Esposa (o de la madre)

☐ Employed/ *Empleado*
  ☐ Full Time (35-40 hours) *Tiempo Completo (35-40 horas)*
  ☐ Part Time (34 or less hours) *Medio Tiempo (34 horas o menos)*
☐ Retired/ Retirado
☐ Unemployed/Desempleado

Source of Income:

Monthly Salary *Salario Mensual* $________

SSI/Social Security *Ingresos Del Serguo Social /Discapacidad* $________

Pension/Retirement *Ingresos Del Retiro* $________

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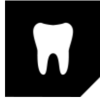
Monthly Salary *Salario Mensual* $________

SSI/Social Security *Ingresos Del Serguo Social /Discapacidad* $________

Pension/Retirement *Ingresos Del Retiro* $________

For office use only: Total Income____________________________________

Solo para uso de oficina: Ingresos Totales______________________________



Dental Patient Consent Form

Problems arising from dental treatment are extremely rare but may include pain or infection. Not treating dental disease may have the same result. If a tooth cavity is very deep and the nerve and blood supply are affected, or if bone loss or swelling are present, the removal of the nerve or the tooth with local anesthesia, may be necessary. Please feel free to discuss any concerns you have with the Dentist.

I. Consent for Treatment

By requesting care at the Charlottesville Free Clinic I give permission for the staff dentist, hygienist, volunteer dental providers and/or 4thyear Dental Students (VCU students supervised by an approved licensed provider) engaged with the Charlottesville Free Clinic to diagnose and treat me. I understand that all the health professionals at the Free Clinic are appropriately licensed and will observe accepted professional standards of care. I understand that all licensed health care professionals, who's names and license number are on file with the VA Department of Risk Management, are immune from professional liability while providing services as a volunteer.

II. Consent for Dental Services

I understand that The Charlottesville Free Clinic offers limited dental services and that the Dental Program depends upon volunteer providers whose availability is limited to specifically scheduled clinics. I understand that the services provided are not guaranteed to be completed within any specific time frame. If I should require further appointments this may involve placing my name on a waiting list which may be extensive with no specific service date provided. It is my responsibility to inquire about making an appointment for further care. I understand that once I have expressed the need for further care I will be contacted regarding any scheduled appointments and am responsible for providing to the Clinic current contact information and/or any change in my demographic or health information.
It is my understanding that return appointments are given as recommended by the provider and at the discretion of the staff. If I have any questions regarding my appointments I may discuss this with the staff.

III. Notice of Deemed Consent for HIV HBV and HCV Testing

If you or one of our health care professionals, volunteers or employees should be directly exposed to blood or body fluids in a way that may transmit disease, your blood and that of the other person involved will be tested for infection with Human Immunodeficiency Virus (HIV, the AIDS Virus) and for the presence of the Hepatitis B and Hepatitis C Viruses. A physician or the health care provider will tell you and that person the result of the test and provide counseling if necessary.

Signature:____ Date:_______________________
(Patient or Parent/Guardian)

Permission to release dental records:

I hereby grant the Charlottesville Free Clinic-Dental permission to release dental records and information for myself or the child for whom I am parent/guardian to:

Referral Doctors, Dentists and Specialists ____Yes _____No

Family / Friends _____Yes _____No, if yes please list____

Signature:____________________________________ Date:_______________________
(Patient or Parent/Guardian)

For Office use only:

MEDICAL HISTORY UPDATE

DATE					
SIGNATURE					