EDCHC
El Dorado Community Health Centers

Medical Tel: (530) 621-7700
Fax: (530) 621-7713
Dental Tel: (530) 497-5016
Fax: (530) 622-8908

Welcome to El Dorado Community Health Centers

We are pleased that you have chosen us for your dental care. Our team is committed to providing high-quality, patient-centered services in a comfortable and welcoming environment.

Dental Locations & Office Hours

Placerville – 4212 Missouri Flat Road, Placerville CA, 95667	
Monday - Friday: 8:00 am – 12:00 pm, 1:00 pm – 5:00 pm	**Saturday:** CLOSED
Cameron Park 2 – 3100 Ponte Morino Dr. STE 120, Cameron Park, CA 95682	
Monday – Friday: 8:00 am – 12:00 pm, 1:00 pm – 5:00 pm	**Saturday:** CLOSED
South Lake Tahoe – 3443 Lake Tahoe Blvd. #2, South Lake Tahoe, CA 96150	
Monday – **Friday:** 8:00 am – 12:00 pm, 1:00 pm – 5:00 pm	**Saturday:** CLOSED

Before Your Appointment

Please arrive 30 minutes early to complete the check-in process. If you need to cancel or reschedule, please call us at least 24 hours in advance.

What to Bring to Your Appointment

- Current medications and/or vitamins you are taking
- Current Medi-Cal card or Sliding Fee Discount Program card
- Valid Photo ID (Drivers Lic, Passport, Student ID)
- Any legal paperwork including Advanced Directive and guardianship documentation

Insurance, Copays & Payments

We participate with Medi-Cal. Co-payments and deductibles are due at the time of service and may be paid by cash, check, Visa, or MasterCard.

Uninsured patients may be eligible to receive a discount through the Sliding Fee Program. Discounts are based on family size and household income.

Contact Us

If you have questions, please call us at 530-497-5016.

We are glad you have chosen El Dorado Community Health Centers as your Dental Provider, and we look forward to providing you with the best care.

Sincerely,

The Staff and Providers at El Dorado Community Health Centers.

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DENTAL HEALTH HISTORY

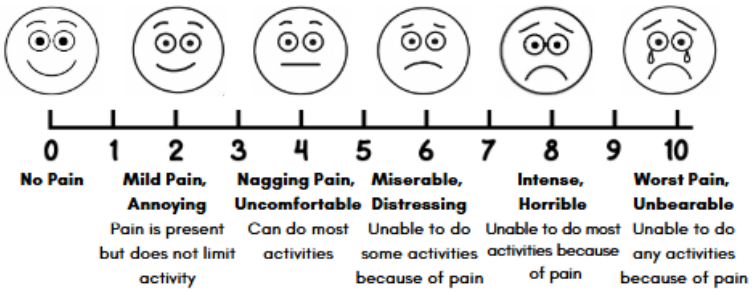
Patient Name: _____ Date of Birth: ____/____/_____

Name of Previous Dentist: _____ Date of Last Visit: _____

Reason for Today's Visit: _____

Primary Insurance: _____ Secondary Insurance: _____

Using the pain scale below, please circle your current pain level: 1 2 3 4 5 6 7 8 9 10



	YES	NO
Are you anxious about dental treatment?	☐	☐
Have you had problems with previous dental treatment?	☐	☐
Do you gag easily?	☐	☐
Do you wear dentures?	☐	☐
Does food catch between your teeth?	☐	☐
Do you have difficulty chewing your food?	☐	☐
Do you chew only on one side of your mouth?	☐	☐
Have you ever noticed slow-healing sores in or around your mouth?	☐	☐
Are your teeth sensitive?	☐	☐
Do you feel pain when your teeth come in contact with:		
Hot food or liquids?	☐	☐
Cold foods or liquids?	☐	☐
Sours?	☐	☐
Sweets?	☐	☐
Do you take fluoride supplements?	☐	☐
Do you clench or grind your teeth?	☐	☐
Does your jar ever feel tired?	☐	☐
Do you have frequent headaches?	☐	☐
Have you ever heard popping or clicking near your ear when you chew?	☐	☐
Do you snore?	☐	☐
Have you ever taken antibiotic pre-medication prior to dental treatment?	☐	☐
If yes, please explain: _____		
How often do you brush your teeth?	☐	☐
What brand of toothpaste do you use?	☐	☐
How do you feel about your smile?	☐	☐

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MEDICAL INFORMATION

Primary Care Provider Name: _____ Phone: _____

Address: _____

Are you in good health? ☐Yes ☐No Date of last physical exam: _____

Have you had a serious illness, operation, or been hospitalized in the last 5 years? ☐Yes ☐No
If yes, please explain: _____
_____

Please list any surgeries you have had: _____
_____

Are you taking or have recently taken any prescription over the counter medicine(s): ☐Yes ☐No
If yes, please list all, including vitamins, natural herbal preparations and/or diet supplements:
_____

Do you wear contact lenses? ☐Yes ☐No

Joint Replacement: Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?
Date: _____ Any Complications? _____

Have you ever taken bone loss prevention drugs such as an Alendronate (Fosamax©), Risedronate (Actonel©), Boniva, or other bisphosphonates? ☐Yes ☐No

Do you use controlled substances (drugs) ☐Yes ☐No
If yes, what kind and for how long: _____

Do you use tobacco (smoking, snuff, chew, bidis)? ☐Yes ☐No *If yes, for how long?* _____

Do you drink alcoholic beverages? ☐Yes ☐No If yes, how much do you drink in a week? _____

Allergies: Are you allergic to or had a reaction to:

Penicillin or other antibiotic	☐Yes ☐No	Metals	☐Yes ☐No
Aspirin, Ibuprofen (NSAIDS)	☐Yes ☐No	Latex (Rubber)	☐Yes ☐No
Sulfa Drugs	☐Yes ☐No	Iodine	☐Yes ☐No
Codeine or other narcotics	☐Yes ☐No	Other: _____	☐Yes ☐No

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS?

Artificial heart valve	☐Yes ☐No	Congenital Heart Disease (CHD)	
Previous Infective Endocarditis	☐Yes ☐No	Unrepaired, cyanotic (CHD)	☐Yes ☐No
Damaged Heart Valves	☐Yes ☐No	Repaired CHD	☐Yes ☐No

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Cardiovascular Disease	☐Yes ☐No	Emphysema	☐Yes ☐No
Angina	☐Yes ☐No	Sinus Trouble	☐Yes ☐No
Arterioclerosis	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Congestive Heart Failure	☐Yes ☐No	Cancer/Chemotherapy/Radiation Treatment	☐Yes ☐No
Heart Attack	☐Yes ☐No		
Stroke or TIA	☐Yes ☐No	Chest Pain upon Exertion	☐Yes ☐No
Heart Murmur	☐Yes ☐No	Chronic Pain	☐Yes ☐No
Low Blood Pressure	☐Yes ☐No	Diabetes Type I	☐Yes ☐No
High Blood Pressure	☐Yes ☐No	Diabetes Type II	☐Yes ☐No
Other Congenital Heart Defects	☐Yes ☐No	Eating Disorder	☐Yes ☐No
		Malnutrition	☐Yes ☐No
Mitiral Valve Prolapse	☐Yes ☐No	Heartburn / Gastroesophageal Reflux Disease (GERD)	☐Yes ☐No
Pacemaker	☐Yes ☐No		
Rheumatic Fever	☐Yes ☐No	Ulcers	☐Yes ☐No
Rheumatic Heart Disease	☐Yes ☐No	Thyroid Problems	☐Yes ☐No
Anemia	☐Yes ☐No	Glaucoma	☐Yes ☐No
Blood Transfusion	☐Yes ☐No	Hepatitis, Jaundice, or Liver Disease	☐Yes ☐No
Hemophilia	☐Yes ☐No		
AIDS or HIV infection	☐Yes ☐No	Epilepsy	☐Yes ☐No
Arthritis	☐Yes ☐No	Fainting Spells or Seizures	☐Yes ☐No
Autoimmune Disease	☐Yes ☐No	Neurological Disorders	☐Yes ☐No
Rheumatoid Arthritis	☐Yes ☐No	*If yes, please specify:* _____	
Lupus	☐Yes ☐No	Sleep Disorder	☐Yes ☐No
Asthma	☐Yes ☐No	Mental Health Disorder	☐Yes ☐No
Bronchitis	☐Yes ☐No	*If yes, please specify:* _____	

WOMEN ONLY Are you: Pregnant? ☐Yes, number of weeks: ____ ☐No
Taking birth control pills or hormonal replacement? ☐Yes ☐No Nursing: ☐Yes ☐No

ACKNOWLEDGMENT OF HEALTH INFORMATION

I certify that the health and dental information I have provided is complete and accurate to the best of my knowledge. I understand that this information is used by my dentist and the dental care team to provide safe and appropriate care, and that I must inform the dental staff of any changes to my health history. **Initials:** _____

Dental Provider Signature: _____

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DENTAL SCHEDULING PROTOCOL

Our dental team wants to make sure you and others in our community can get dental care when it is needed. Because appointment times are limited, please review and follow the rules below.

Appointment Confirmation:
We will try to remind you of your dental appointment by phone or mail. However, you are responsible for remembering the date and time of your appointment. **Initials:** _____

Timely Cancellations
If you cannot come to your appointment, you must call us at least 24 hours in advance. This allows us to give your time to another patient. If you do not give at least 24 hours' notice, it will count as a missed appointment. **Initials:** _____

On-Time Arrivals
Please arrive on time for your appointment. If you arrive more than 10 minutes late, your appointment will be considered missed and may be given to another patient. **Initials:** _____

Missed Appointments and Compliance
Because dental care access is limited in our area, missed appointments are taken seriously.

- After one missed appointment, it will be noted in your record.
- After two missed appointments in the same calendar year without proper notice, you will be placed on no-show status.

To continue receiving care, you will be required to write a letter to the Dental Director explaining:

1. Why you missed your last appointment
2. Why you need another appointment
3. That you understand another missed appointment may result in being discharged from the dental office

Important Notice for Parents
Parents or guardians of children with untreated dental decay should understand that dental infections can be serious and may become life-threatening. Repeated failure to bring a child to scheduled dental appointments may be considered neglect or abuse. **Initials:** _____

If you have any questions about this Dental Scheduling Protocol, please speak with a member of our dental staff.

DENTAL MATERIALS FACT SHEET ACKNOWLEDGEMENT

I acknowledge that I have received and reviewed the Dental Materials Fact Sheet, which provides information about the materials used in my dental treatment. The Dental Materials Fact Sheet is available at the front desk upon request. www.dbc.ca.gov **Initials:** _____

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ACKNOWLEDGMENT AND ATTESTATION

I certify that the information I have provided in this Dental Intake Packet is complete and accurate to the best of my knowledge. I understand that this information is used by my dentist and the dental care team to provide safe and appropriate care, and that it is my responsibility to inform the dental staff of any changes to my health history.

I acknowledge that I have reviewed, understand, and agree to the information contained in this packet, including the Dental Scheduling Protocol. I understand that sections requiring my initials indicate specific acknowledgment of those items.

I understand that the dental office is not responsible for any problems or complications that may result from missing, incomplete, or incorrect information that I have provided.

Signature: _____ **Date:** _____

If signed by someone other than patient, complete below:

Print name: _____

By signing, I attest that I have authority under applicable law to act for the patient with respect to the information and timeframe described in this authorization.

Legal authority: (select one): ☐ Parent/Legal Guardian ☐ Conservator
☐ Agent under Health Care Power of Attorney ☐ Executor/Personal Representative of Estate
☐ Other (specify): _____

Documentation: (attach if applicable): ☐ Health Care Power of Attorney ☐ Court Order
☐ Letters of Conservatorship ☐ Other: _____