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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PATIENT INFORMATION

Name: _____ Other Name(s) used: _____
Mailing Address: _____
Street Address: _____
Cell Phone (____) _____-_____ Alternative Phone: ☐ Home ☐ Work (____) _____-_____
Can we text you? ☐Yes ☐No Can we leave a voice message? ☐Yes, Brief ☐Yes, Extended ☐No
Email Address: _____ Patient Portal Access: ☐ Yes ☐ No
Preferred Language: _____ Date of Birth: ____/____/_____ SSN: _____ -___-____
Gender Assigned at Birth: ☐ Male ☐ Female
Marital Status (please mark one): ☐Single ☐Married ☐Divorced ☐Widowed ☐Separate ☐Other
Do you have an Advanced Directive for Health Care? ☐Yes ☐No ☐Interested
If yes, please provide a copy of your Advanced Directive to the front desk

RESPONSIBLE PARTY *(If the patient is a minor - parent or legal guardian complete this section.)*

Name: _____ Relationship: ☐Mother ☐Father ☐Other: _____
Phone: ☐Home ☐Cell ☐Work (____) _____ - _____ SSN of Parent/Guardian: ____ -___-_____
Date of Birth: _____ ☐ Emergency Contact

INSURANCE

Insurance Carrier: _____
ID/Policy number: _____
Group Name/Number: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____
Cell (_____) _____-_____ Alternative Phone: ☐Home ☐Work (_____) _____-_____

PHARMACY

☐ EDCHC Placerville Pharmacy – 4212 Missouri Flat Road, Placerville
☐ EDCHC Cameron Park Pharmacy – 3104 Ponte Morino Drive STE. 100, Cameron Park
☐ Other Pharmacy Name/Location: _____

LAB AND DIAGNOSTIC IMAGING

Preferred Lab Company (select one): ☐ Quest Lab ☐ Marshall Lab ☐ Other: _____
Preferred Imaging Company: ☐ Marshall Imaging ☐ Other: _____

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ADDITIONAL INFORMATION

1. **Are you a U.S. Veteran? *** ☐ Yes ☐ No

2. **Would you consider yourself unhoused at any time in the last 12 months? *** ☐ Yes ☐ No
   If yes, where have you stayed? ☐ In your Car ☐ In a hotel ☐ With Family/Friend
   ☐ In a Shelter ☐ On the Street ☐ Other: _____

3. **Are you currently in a public housing or low-income housing program? *** ☐ Yes ☐ No

4. **Total number of people living in household**:* _____
   Total yearly income earned by family household*: $ _____. ___
   (Does not include Social Security or Disability payments)

5. **Pronouns:**
   ☐ He/Him/His/Himself ☐ She/Her/Hers/Herself ☐ They/Them/Their/Themselves
   ☐ Ze/Zem/Zir/Zirself ☐ Xie/Hir/Hirs/Hirself ☐ Other (please specify): _____

6. **Sexual Orientation:**
   ☐ Heterosexual (Straight - not lesbian or gay) ☐ Homosexual (Lesbian or Gay) ☐ Bisexual
   ☐ Choose not to disclose ☐ Do Not Know ☐ Other (please specify): _____

7. **Gender you identify with:**
   ☐ Male ☐ Female ☐ Choose to not disclose ☐ Other (please specify): _____
   ☐ Gender queer (neither exclusively male nor female)
   ☐ Transgender Male (Female-to-Male) Date of Transition: _____
   ☐ Transgender Female (Male-to-Female) Date of Transition: _____

8. **Race**:
   ☐ American Indian/Alaska Native ☐ Guamanian or Chamorro ☐ Samoan
   ☐ Asian Indian ☐ Japanese ☐ Vietnamese
   ☐ Black/African American ☐ Korean ☐ White
   ☐ Chinese ☐ Native Hawaiian ☐ Other Race: _____
   ☐ Filipino ☐ Other Pacific Islander ☐ Declined to Specify

9. **Ethnicity (choose one):**
   ☐ Chicano ☐ Mexican American
   ☐ Cuban ☐ Puerto Rican
   ☐ Hispanic/Latino ☐ Non-Hispanic/Latino
   ☐ Mexican ☐ Declined to Specify
   ☐ Other Hispanic, Latino, or Spanish Origin (please specify): _____

10. **Work Status: *** ☐ Employed Full-Time ☐ Employed Part-Time ☐ Not Employed
    ☐ Self-Employed ☐ Retired ☐ Other: _____
    Employer's Name*: _____ Employer's City/Location*: _____

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11. How did you hear about us? ☐Family Member ☐Friend ☐EDCHC Signage/Mobile Service ☐ Another Agency ☐ Social Media ☐Internet ☐Event/Booth ☐ Newspaper/TV/Radio

12. Do you have a dentist? ☐ None
☐ EDCHC Dentist, last visit date: _____ ☐ Other Dentist, last visit date: _____

13. Do you have an Eye Care provider? ☐ None
☐ EDCHC Eye Care, last visit date: _____ ☐Other Eye Care Specialist, last visit date: _____

PATIENT RIGHTS AND RESPONSIBILITIES ACKNOWLEDGEMENT

I have read and understand the Patient's Rights and Responsibilities. I acknowledge my responsibility to uphold these principles and comply with the guidelines outlined. www.edchc.org **Initials:** _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Healthcare operations which include the business aspects of running our practice. Examples of this include appointment confirmation calls, voicemail messages, letters to home address, discuss with/allow immediate family members/guardians into the exam process to support the understanding go the treatment options when necessary.

I acknowledge that I have received and reviewed the Notice of Privacy Practices, which explains how my personal health information may be used and disclosed. I understand my rights regarding this information and how I can access it. The Notice of Privacy Practices is available at the front desk, upon request, and by visiting www.edchc.org. **Initials:** _____

PATIENT INFORMATION GUIDE

I have read and understand the Patient Information Guide. I acknowledge my responsibility to follow the guidelines, policies, and expectations outlined within it. www.edchc.org **Initials:** _____

AI DICTATION

El Dorado Community Health Centers may use AI technology to improve the efficiency and accuracy of documenting my health information. The AI system is used to assist in transcribing medical notes and all information is handled securely in compliance with privacy regulations, including HIPAA. If I consent, my health information will be protected, and access to the AI documentation will be limited to authorized personnel only.

SLIDING FEE DISCOUNT PROGRAM

As an FQHC, our Centers offer a sliding fee program based on family size and household income. Our staff can help you with questions regarding sliding fee discount program.

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PAYMENT POLICY

As a private organization committed to providing affordable, high-quality care to our community, we rely on prompt payment for services rendered.

Insurance Billing: We will bill your primary insurance carrier on your behalf. For Medicare patients, we will also bill your supplemental insurance when applicable.

Payment Responsibilities:

- Co-pays and unmet deductibles are due at the time of service.
- Any remaining balance after your insurance has paid will be billed directly to you.
- Payment is due upon receipt of your billing statement.

Insurance Card/Sliding Fee Discount Program Card Requirement: Please present your current insurance or Sliding Fee Discount Program card at each visit to ensure accurate billing.

Payment Arrangements: If you are unable to pay at the time of service, you must contact our billing department in advance to discuss payment arrangements.

CONSENT

To provide medical treatment, coordinate your clinical care, bill your insurance, or release information required by your insurance carrier, we must obtain your consent. Please read the statements below, initial each section to indicate your understanding and agreement, and sign at the bottom of the form.

1. **Consent for Treatment:** I authorize and consent to all necessary medical evaluations, procedures, and treatments for myself (or for my child/dependent listed above) while receiving care at El Dorado Community Health Centers. **Initials:** _____
2. **Release of Information:** I authorize El Dorado Community Health Centers to release any medical or other information required for coordination of clinical care and for billing purposes, including submission of claims to my insurance provider for myself (or my child/dependent listed above). **Initials:** _____
3. **Assignment of Benefits:** I authorize payment of medical benefits directly to El Dorado Community Health Centers for services provided to me or to my child/dependent listed above. **Initials:** _____

Your signature below indicates you have read, understand, and agree to the payment policy, and consents.

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 to request/access records: (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: _____

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EDCHC AUTHORIZATION FOR THE RELEASE OF INFORMATION

Print Patient's Name: _____ Date of Birth: _____

I authorize El Dorado Community Health Centers (EDCHC) to discuss and share my protected health information with the following person:

Name: _____ **Relationship**: _____ **Phone**: _____

Purpose of authorization: _____
Examples include care coordination, billing inquiry, personal support, and legal or insurance matters; this is not an all-inclusive list of PHI that may be shared.

Please share the following information:
☐ Medical ☐ Dental ☐ Eye Care ☐ Chiropractic ☐ Behavioral Health
☐ Psychiatry ☐ STEPS/Substance Use Disorder (SUD) Treatment ☐ Billing

By initialing below, I authorize EDCHC to share my sensitive information

_____ Alcohol/Drugs/Substance Use Disorder (SUD) Treatment
_____ Behavioral Health
_____ Psychiatry
_____ Reproductive Health
_____ HIV/AIDS
_____ Genetic Information

*Psychotherapy notes Exclusion: This authorization does not permit disclosure of Psychotherapy notes as defined by HIPAA.

EXPIRATION: This authorization expires on (date): ____/____/_____ unless revoked earlier in writing or upon my death.

Acknowledgement and Understanding

- I understand that this authorization is in effect until the expiration date listed above, until I revoke it in writing, or upon my death.
- I understand that authorizing the release of my protected health information is voluntary, and I have the right to refuse to sign this authorization. My refusal will

not affect my ability to receive treatment, nor will it impact my payment, enrollment, or eligibility for benefits.

- I understand I may revoke this authorization at any time by submitting a written revocation to EDCHC. Revocation does not affect disclosures made in reliance on this authorization before EDCHC receives my revocation.
- I understand I have the right to receive a copy of this authorization.
- This authorization does not permit the request or release of copies of my health records; a separate Release of Records form is required.
- This authorization does not authorize healthcare decision-making.
- This authorization does not authorize consent for treatment of a minor; a separate Consent to Treat form is required.
- I understand that once information is shared with the authorized recipient, it may no longer be protected by HIPAA. California law generally prohibits further disclosure without my authorization or as required/permitted by law; certain categories (HIV test results, behavioral health, psychiatry, substance use disorder (SUD) treatment, reproductive health, and genetic information) have additional restrictions.

If Applicable:

- For minors and sensitive services: if the patient is a minor, information for certain services the minor may consent to (e.g., reproductive health, STI care, outpatient mental health counseling, and substance use disorder services) may require the minor's authorization and may not be shared with a parent/guardian unless permitted by law.
- Substance Use Disorder (SUD) Treatment Information. If SUD information protected by 42 C.F.R. part 2 is authorized to be released, fill in the following:

  Recipient (name/class): _____

  What kind of information: _____

  How much and/or timeframe: _____

  Purpose: _____

  You may revoke in writing at any time (except to the extent already relied upon). A Part 2 prohibition-on-redisclosure notice will accompany any disclosure.

Contact for Questions/Revocations:

Health Information Management
4212 Missouri Flat Road, Placerville, CA 95667
Phone: 530-621-7700 ext. 2030 Email: medicalrecords@edchc.org

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RELEASE OF INFORMATION

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 □ Agent under Health Care Power of Attorney □ Conservator □ Executor/Personal Representative of Estate □ Other (describe): _____

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

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DENTAL HEALTH HISTORY

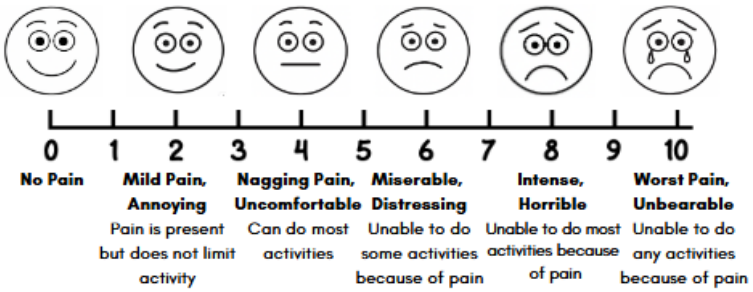
Patient Name: _____ Date of Birth: ____/____/_____

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: _____