COMMUNITY DENTAL CLINIC

3428 Armour, Fort Smith AR 72904

Phone: 479-782-6021 Email: communitydental17@gmail.com

Check ☑	**To be a CDC patient you must be able to check all the boxes & meet income guidelines: If over income may still apply for service based on your income for reduced fees. *We cannot accept incomplete applications***
	You must live in Crawford or Sebastian County. Include one Utility Bill (GAS, ELECTRIC or WATER) with YOUR physical Address. Letters from shelter are ACCEPTED.
	Copy of **Picture ID for the patient and anyone in the home over 18.**
	Copy of **Social Security Cards for all individuals in the household.**
	I certify I do not have **Dental Insurance** or **Dental Covered Medicaid** located on **Intake page of application.**
	For anyone working: copies of **5** recent **check stubs (**this applies to anyone working in the home regardless if they're related or not). **No income ask for a zero income check list.**
Warning: **3 steps must be completed in this section.** **1.** _____ **2.** _____ **3.** _____	**1.** Everyone in the home including children must have a letter from the **Social Security Office.** Stating you DO or DO NOT Receive a benefit or that it is pending. (Security office located @ 6801 Dallas St.) **2**. If divorced or separated a letter from the Child Support Office for any children that you're the custodial parent must be included.(Child Support office is located @ 3132 Alma Blvd , Van Buren) **3.** 18 and over must have a Review Claim Transaction from the **UNEMPLOYMENT OFFICE**, even if you receive SSI, SSA, or SSD. (Unemployment office located @ 616 Garrison Ave #101 Fort Smith)

United Way of Fort Smith Area

DELTA DENTAL

THE DEGEN FOUNDATION

"We have all drunk from wells we did not dig; We have been warmed by fires we did not build; We have sat in the shade of trees we did not plant; We are where we are

CDBG COMMUNITY DEVELOPMENT BLOCK GRANT

READ and SIGN THIS PAGE –

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

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.

- **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.**
- **Non- English speaking patients should have a translator with them at all dental appointments.**
- **A pregnant patient must have a note from her doctor giving permission for an X-ray and treatment.**
- **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!**
- **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.**
- **We have a limited denture program. DENTURES ARE ONLY AVAILABLE WHEN WE HAVE FUNDING.**
- **Every person applying for dental treatment will need their own application.**
- **DO NOT BRING CHILDREN TO YOUR DENTAL APPTOINTMENT.**
- **This is a DRUG FREE Establishment: Alcohol & drugs are not allowed at the Community Dental Clinic.**
- **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.**
- **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.**
- **NO pets are allowed in the building. DO NOT BRING YOUR PETS.**
- **NO SMOKING IN and OR on property of THE DENTAL CLINIC. IF YOUR NAME IS CALLED AND YOU ARE OUTSIDE SMOKING IN YOUR VEHICLE, YOUR DENTAL APPOINTMENT WILL BE RESCHEDULED.**

Patient Signature_____ Date: _____

Patient Health History

PLEASE PRINT

Patient Name_____ Date of Birth_____

	YES	NO
Are you in good health?		
Are you under a Doctor's care?		
Date of last physical exam:		
Name of Primary Doctor:		
Phone # of Doctor:		
NOTE: If you have heart problems, joint replacement, or are pregnant we will need a note from your doctor concerning treatment.		
Have you been hospitalized for a serious illness or operation?	**Yes**	**No**
Are you taking any medications?		
If yes, what medications do you take: _____ _____ _____ _____ _____ _____ _____ _____ _____		
Do you take a blood thinner? If yes, which one?		

	YES	NO
Have you had abnormal bleeding?		
Problems when teeth pulled?		
Have you ever had a blood transfusion?		
Have you had a recent weight loss without cause?		
Do you use tobacco products? If so, what type:		
Have you used controlled substances? Chemical Dependency?		
Do you drink alcohol?		
Do you have a persistent cough or throat clearing not due to a known illness?		
If you are female:	YES	NO
Are you pregnant?		
Due Date:		
Are you nursing?		
What is your dental need:		

HEALTH INFORMATION & ALLERGIES

ALLERGY OR REACTION TO:	**YES**	**NO**
Local anesthetics like Novocain		
Penicillin		
Sulfa Drugs		
Pain medications (**Lorcet, Lortab, codeine**)		
Aspirin		
Tylenol/Ibuprofen		
Any metals (i.e. nickel, mercury, etc.)		

HEALTH HISTORY continued	YES	NO
Diabetes		
Eating Disorder		
Enlarged Lymph glands		
Epilepsy or Seizures		
Gastric Bypass		
Heart Trouble: Heart Attack, Angina, Chest Pain		
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 CONTINUED**

PLEASE PRINT

Patient Name_____ Date of Birth_____

	YES	NO		YES	NO
Latex/Rubber			**Mitral Valve Prolapse**		
Other? Please List: medicines you are allergic to: _____ _____ _____ _____ _____			**Heart Defect or Heart Murmur**		
			Hepatitis		
			High Blood pressure		
			Hives or skin rash		
			Hypoglycemia (low blood sugar)		
	YES	NO	**Joint/Bone replacement or implant**		
Foods			Kidney Dialysis, Transplant, or Disease		
If yes, please list:			Nervous Disorders/Depression		
			Pancreatitis		
			PTSD		
HEALTH HISTORY	YES	NO	Rheumatic Heart Disease/Rheumatic Fever		
Acid Reflux			Scarlet Fever		
AIDS or HIV Infection			Shortness of Breath		
Anemia			Stomach ulcer		
Arthritis			Stroke		
Asthma or Breathing Problems			Swelling of feet, ankles, hands		
Autoimmune Disorder – (Lupus, Rheumatoid Arthritis)			Thyroid Problems		
Cancer -			Tuberculosis		
Cortisone Treatment			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.

Patient Signature _____ **Date:** _____

INTAKE/PATIENT PROFILE PLEASE PRINT

APPLICATION DATE: _____

Patient Name:_____ **SS#**_____-____-_____

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:

SINGLE: _____ **MARRIED:**_____ **SEPERATED:**_____**DIVORCED:**_____ **WIDOWED:**_____

ARE YOU A: SINGLE PARENT_____ **2 PARENT HOUSEHOLD**_____ **DIVORCED With CHILDREN**_____

HOMELESS:_____ **OTHER:**____ **MULTI GENERATION:**_____

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

ARE YOU A FARMER: YES:____ **NO:**_____ **SEASONAL FARMER:**_____

TYPE OF INCOME:

EMPLOYED:_____ **UNEMPLOYED:**_____ **UNEMPLOYED HOW LONG:**_____ **BENEFIT:**_____

DO YOU RECEIVE: SSA ___ **SSI**_____ **SSD**_____ **Child Support**_____ **Pension**_____ **Other**_____

INCOME amount:$_____ **WEEKLY:**_____ **BI WEEKLY:**____ **MONTHLY:**_____

IF NO INCOME, ASK FOR ZERO INCOME CHECK LIST.

DO YOU RECEIVE: FOOD STAMPS:____ **TEA:**_____ **HUD:**_____ **GENERAL ASSISTANCE:**_____

ARE YOU Disabled: YES or NO or PENDING

Are you a VETERAN: Yes or No VA Benefits Amount $_____

Dental Insurance: I certify that I do not have Dental Coverage:

Signature_____ **Date:**_____

Health Insurance: YES____ **NO**_____

TYPE OF INSURANCE:_____

Education level:

NON Grad:_____ **GRADUATE:**_____**GED:**_____ **12+ Post-Secondary** _____
2 or 4 years college _____

FAMILY or ADDITIONAL HOUSEHOLD INTAKE INFORMATION IS LOCATED AT THE END OF APPLICATION
PLEASE MAKE SURE TO ANSWER ALL QUESTIONS FOR EACH FAMILY MEMBER, WE CAN NOT ACCEPT INCOMPLETE APPLICATIONS.

HH member #2

Relationship to PATIENT: _____ MALE____ or FEMALE___ SOCIAL SECURITY:_____

Name:_____ DATE OF BIRTH: ____/____/_____ AGE _____

SINGLE: _____ MARRIED:_____ SEPERATED:_____DIVORCED:_____ WIDOWED:_____

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

TYPE OF INCOME:
EMPLOYED:_____ UNEMPLOYED:_____UNEMPLOYED HOW LONG:_____ BENEFIT_____

DO YOU RECEIVE: SSA ____ SSI_____ SSD_____ VA_____PENSION_____ Child Support_____

INCOME amount:$_____ WEEKLY:____ BI WEEKLY:___ MONTHLY:_____

IF NO INCOME, ASK FOR ZERO INCOME CHECK LIST.

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

Are YOU Veteran:_____ ARE YOU Disabled: _____

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

Your Education level:

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

HH member #3

Relationship to PATIENT: _____ MALE____ or FEMALE___ SOCIAL SECURITY:_____

Name:_____ DATE OF BIRTH: ____/____/_____ AGE _____

SINGLE: _____ MARRIED:_____ SEPERATED:_____DIVORCED:_____ WIDOWED:_____

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

TYPE OF INCOME:
EMPLOYED:_____ UNEMPLOYED:_____UNEMPLOYED HOW LONG:_____ BENEFIT_____

DO YOU RECEIVE: SSA ____ SSI_____ SSD_____ VA_____PENSION_____ Child Support_____

INCOME amount:$_____ WEEKLY:____ BI WEEKLY:___ MONTHLY:_____

IF NO INCOME, ASK FOR ZERO INCOME CHECK LIST.

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

Are YOU a Veteran:_____ ARE YOU Disabled: _____

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

Your Education level:

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

HH member #4

Relationship to PATIENT: _____ MALE____ or FEMALE___ SOCIAL SECURITY:_____

Name:_____ DATE OF BIRTH: ____/____/_____ AGE _____

SINGLE: _____ MARRIED:_____ SEPERATED:_____DIVORCED:_____ WIDOWED:_____

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

TYPE OF INCOME:
EMPLOYED:_____ UNEMPLOYED:_____UNEMPLOYED HOW LONG:_____ BENEFIT_____

DO YOU RECEIVE: SSA ____ SSI_____ SSD_____ VA_____PENSION_____ Child Support_____

INCOME amount:$_____ WEEKLY:____ BI WEEKLY:___ MONTHLY:_____

IF NO INCOME, ASK FOR ZERO INCOME CHECK LIST.

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

Are YOU Veteran:_____ ARE YOU Disabled: _____

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

Your Education level:

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

HH member #5
Relationship to PATIENT: _____ MALE____ or FEMALE___ SOCIAL SECURITY:_____

Name:_____ DATE OF BIRTH: ____/____/_____ AGE _____

SINGLE: _____ MARRIED:_____ SEPERATED:_____DIVORCED:_____ WIDOWED:_____

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

TYPE OF INCOME:
EMPLOYED:_____ UNEMPLOYED:_____UNEMPLOYED HOW LONG:_____ BENEFIT_____

DO YOU RECEIVE: SSA ____ SSI_____ SSD_____ VA_____PENSION_____ Child Support_____

INCOME amount:$_____ WEEKLY:____ BI WEEKLY:___ MONTHLY:_____

IF NO INCOME, ASK FOR ZERO INCOME CHECK LIST.

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

Are YOU Veteran:_____ ARE YOU Disabled: _____

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

Your Education level:

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

Community Dental Agreement

PLEASE READ AND INITIAL EACH LINE AND SIGN AFTER READING

❖ **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. 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. _____**
- ❖ **I certify I do not have Dental Coverage or Dental Covered Medicaid. _____**

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: _____

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:

- **Swelling and/or bruising and discomfort in the surgery area.**
- **Stretching of the corners of the mouth resulting in cracking or bruising.**
- **Possible infection requiring additional treatment.**
- **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.**
- **Possible damage to adjacent teeth, especially those with large fillings or caps.**
- **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.**
- **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.**
- **Bleeding-significant bleeding is not common, but persistent oozing can be expected for several hours.**
- **Sharp ridges or bone splinters may form later at the edge of the socket. These usually require another surgery to smooth or remove.**
- **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.**
- **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.**
- **Jaw fracture – although quite rare, it is possible in difficult or deeply impacted teeth.**
- **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.**

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:** _____

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: _____

DENTURE / PARTIAL PROGRAM CONTRACT

PLEASE READ AND INITIAL EACH LINE AND SIGN AFTER READING

Patient Name: _____ Date: _____

1. **The partials/dentures are $750.00 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. _____

Many times you will need a soft reline in the first 2 months of a denture after extraction, this soft liner is temporary and can last up to 3 months. Soft liners are not covered by Community Dental Clinic, and is a separate fee._____

After 6 months you may require a HARD Reline as your gums will have continued to shrink causing a loose fitting denture. A Hard reline is permanent, and will give your denture a more tight fit. Hard Relined are not covered by Community Dental Clinic, and is a separate fee. _____

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: _____

Agreement to Receive Electronic Communication

Patient Name:_____Date of Birth:_____

(Initial below)

I DO AGREE _____

I DO NOT AGREE _____

That the dental practice may communicate with me electronically at the email address and/or mobile phone number listed below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I further agree that I am responsible for providing the dental practice any updates to my email address and/or mobile phone number.

My most preferred method of electronic communication: (Initial Below)

_____ Text Messaging

_____ Email

I would like to receive:

_____Appointment Reminders/Recall Visits

_____Information regarding insurance/billing

_____Requests for Patient Satisfaction online reviews

I can withdraw my consent to electronic communications at any time by calling:

Community Dental Clinic @ 479-782-6021 or Email Communitydental17@gmail.com

Patient Signature:_____Date:_____

Adult-Photo or Video Release Consent Form

Patient Name _____ Date_____

I hereby give my permission to the Community Dental Clinic in Fort Smith, AR located at 3428 Armour to use my photograph or film of me. I hereby waive all rights to the photograph or film and give my permission for these images to be published or distributed publicly.

Including listed below

My Name and photo may be released to outside sources.
My Name and photo may be posted on social media.
My Name and photo may be used in advertisement.

I understand that my refusal to sign will exclude me from being approved for our denture program and dental services, and that I will be charged normal fees.

Please Print Your Name: _____

Signature: _____ Date: _____

Staff Witness Initials: _____