Southern Trinity Health Services, Inc.

Mad River – 321 Van Duzen Road/P.O. Box 4, Mad River, CA 95552, 707-574-6616
Scotia Bluffs – 500 B Street/P.O. Box 7, Scotia, CA 95565, 707-764-5617
Providing Compassionate, High Quality & Preventative Health Care Regardless of Ability to Pay

Name: (First, Middle, Last)		**Gender Identity Required: (circle one)** Transgender male/female to male Transgender female/male to female	Male / Female Other Chose not to disclose	
Sexual Orientation Required: (circle one) Straight or heterosexual Bisexual Lesbian, gay or homosexual Something else Chose not to disclose Don't know	**Date of Birth:**	**Social Security Number Required:**	**Smoker:** Yes / No	**Veteran:** Yes / No
Mailing Address: (Street/P.O. Box- City-State- Zip)				
Email Address Required:		**Pharmacy:** (Name and Location)		
Home Phone Number:	**Cell Phone Number:**		**Work Phone Number:**	
Marital Status: Single / Married / Separated / Divorced / Widowed Name of Spouse (if applicable):_____		**Work Status:** Student / Homemaker / Unemployed / Retired Employed: Full Time / Part Time / Self		
Employer/Company Name:		Occupation:		
Employer Address: (Street-City-State-Zip)			Employer Phone Number:	
Emergency Contact (Name/Relationship) Required:			**Emergency Contact Phone Number:**	
(If Patient Is A Minor) Responsible Party: (Name/Relationship)		Responsible Party Address: (Street/P.O. Box-City-State-Zip)		
Responsible Party Phone Number:	Responsible Party Social Security Number:		Responsible Party Date of Birth:	

May we discuss your medical record information over the phone or in person with your designated personal representative (example: spouse, family member or friend)? Yes / No
If yes, whom?_____

I hereby acknowledge or opt out of receiving a copy of STHS Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgment if I so choose. Refusal __Emergency situation __Communication Barrier__
If you would like a copy of the Notice of Privacy Practices it will be given to you at your request. Initial here____

Signature of Patient / Parent or Guardian_____Date_____

Do you have medical insurance coverage? Insurance card required	Yes / No
Primary Insurance Name:	
Policy/ID Number:	Group Number:
Subscriber Name:	Subscriber's Relationship to Patient:
Subscriber's Social Security Number:	Subscriber's Date of Birth
Subscriber's Employer	
Secondary Insurance Name (if applicable): Insurance card required	
Policy/ID Number:	Group Number:
Subscriber Name:	Subscriber's Relationship to Patient:
Subscriber's Social Security Number:	Subscriber's Date of Birth:
Subscriber's Employer	
Do you have dental insurance coverage? Insurance card required	Yes / No
Dental Insurance Name (if applicable):	
Policy/ID Number:	Group Number:
Subscriber Name:	Subscriber's Relationship to Patient:
Subscriber's Social Security Number:	Subscriber's Date of Birth:
Subscriber's Employer	

Insurance: You are responsible for your insurance coverage and ensuring that the services you receive here are covered under your plan and verifying preferred provider status. You are responsible for notifying us of any changes in your insurance. We will bill your insurance for you, and make a reasonable effort to collect from them, however you remain responsible for what your insurance does not pay.

Co-Payments: You are responsible for your co-payment which is due at time of service, you will be asked to pay it when you check in for your visits.

Private Pay & High Deductible: If you are private pay or have a high deductible, or your insurance will pay you directly, you will be asked to pay for your visit at the time of service. We offer a sliding fee schedule for patients based on federal guidelines.

Sliding Fee Discount Program: It is the policy of STHS to provide services regardless of the patient's ability to pay. Discounts are offered depending upon household income and size per federal guidelines beginning each year on April 1st thru March 31st. The discount will apply to all services received in our office only, but not the services which are purchased from outside.

Please inquire at the front desk if interested in this program to see if you qualify.

Treatment Agreement: for Southern Trinity Health Services: The above information is true to the best of my knowledge. I request STHS to provide me and/or my family with medical and/or dental care.

Payment Agreement: I authorize assignment of benefits for services received to be paid directly to STHS. I understand that I am financially responsible for any balance. I also authorize STHS or my insurance company to release any information required to process my claims.

This includes all minor patients as acknowledged by parent or legal guardian.

Signature of Patient / Parent or Guardian_____Date_____

Demographic Information
The following information is requested by the Federal Government in order to monitor compliance with Federal law prohibiting discrimination against users of Southern Trinity Health Services and Scotia Bluffs Community Health Center. You are not required to furnish this information, but are encouraged to do so. This information will not be used to discriminate against you in any way, nor will it be released except in aggregate form.

Please check one box in each of the following categories:

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino
Race:
☐ Asian
☐ Native Hawaiian
☐ Other Pacific Islander
☐ Black/African American
☐ American Indian/Alaska Native
☐ White (not Hispanic or Latino)
☐ More than one Race
☐ Not Reported/Refuse to Report
Primary Language:
☐ English
☐ Spanish
☐ Other:
Migrant/Seasonal Worker:
☐ Migrant Worker
☐ Seasonal Worker
☐ Not a Migrant/Seasonal Worker
Housing Status:
☐ Doubling Up
☐ Not Homeless
☐ Shelter
☐ Street
☐ Transitional
☐ Unknown/Unreported

Income Category		
	# In Family	Annual Family Income
☐	1	$0-$12,140
☐	1	$12,141-$18,210
☐	1	$18,211-$24,280
☐	1	More Than $24,281
☐	2	$0-$16,460
☐	2	$16,461-$24,690
☐	2	$24,691-$32,920
☐	2	More Than $32,921
☐	3	$0-$20,780
☐	3	$20,781-$31,170
☐	3	$31,170-$41,560
☐	3	More Than $41,561
☐	4	$0-$25,100
☐	4	$25,101-$37,650
☐	4	$37,651-$50,200
☐	4	More Than $50,201
☐	5	$0-$29,420
☐	5	$29,421-$44,130
☐	5	$44,131-$58,840
☐	5	More Than $58,841
☐	6	$0-$33,740
☐	6	$33,741-$50,610
☐	6	$50,611-$67,480
☐	6	More Than $67,481
☐	7	$0-$38,060
☐	7	$38,061-$57,090
☐	7	$57,091-$76,120
☐	7	More Than $76,121
☐	8	$0-$42,380
☐	8	$42,381-$63,570
☐	8	$63,571-$84,760
☐	8	More Than $84,761

Signature of Patient / Parent or Guardian_____**Date**_____

Southern Trinity Health Services

CONSENT FOR DENTAL TREATMENT OF ADULT / MINOR

Patient's Name _____ Date_____

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR BEFORE INITIALING.

____ 1. TREATMENT: I am aware that healthcare is a joint effort between the Provider and the Patient to maintain good health or to correct, improve or prevent worsening of health problems. I understand that as the Patient, I have complete control and make the final decision with regard to my healthcare. I agree that I must be informed in making these decisions, and will request any information I wish from Southern Trinity Health Services' Provider(s) in order to make good decisions. I understand that I may have the following dental treatment performed: Fillings, Crowns, Bridges, Dentures, Extractions, Impacted tooth removal, Root Canals, treatment of periodontal disease or other work deemed necessary.

___ 2. DRUGS AND MEDICATIONS: I understand that I may receive prescribed medications through Southern Trinity Health Services or through a pharmacy of my choice. I understand that antibiotics, analgesics, anesthetics and other medications can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, nausea and vomiting or more severe allergic reactions. I have informed the doctor of any known allergies. Certain medications may cause drowsiness and it is advisable not to drive or operate hazardous equipment when using such drugs.

___ 3. RISKS OF DENTAL ANESTHESIA: I understand that pain, bruising, and occasional temporary or sometimes-permanent numbness in lips, cheeks, tongue or associated facial structure can occur with "shots". About 90% of these cases resolve themselves in less than 8 weeks. Although very rarely needed, a referral to a specialist for evaluation and possibly treatment may be needed if the symptoms do not resolve.

____ 4. FILLINGS: I understand that a more extensive restoration than originally planned, or possibly root canal therapy, may be required due to additional conditions discovered during preparation. I understand that significant changes in response to temperature may occur after tooth restoration. I realize that fillings are rarely "permanent" and usually require periodic replacement with additional fillings and/or crowns.

____ 5. CROWNS, BRIDGES, INLAYS AND ONLAYS: I understand that it is sometimes not possible to exactly match the color of natural teeth with artificial teeth. I further understand that I may be wearing temporary crowns that are prone to loosening and may need re-cementing. I will notify my doctor of that occurrence so that a temporary restoration is maintained until the final restoration is delivered. I realize that any changes I may desire in color, shape, size, etc. of a crown must be made prior to final fabrication. It is my responsibility to return within one month of tooth preparation for final cementation of the restoration. I understand I may need further treatment in this office or possibly by a specialist if complications arise during treatment, and any costs thus incurred are my responsibility.

____ 6. DENTURES: I understand that wearing dentures is not a simple process, that chewing efficiency will be diminished, and that dentures are not "permanent". I also understand that I could experience denture related problems such as; shrinking bone and gums, poor chewing ability, altered speech, reduced taste and constant denture movement. Most denture wearers become used to these symptoms quickly while others take time, and there are a small number of patients who never do. Immediate dentures (placement of a denture immediately after extractions) may be quite uncomfortable for several days. Immediate dentures require frequent adjustments and one or more permanent relines within several months.

____ 7. EXTRACTIONS: Alternatives to tooth removal include root canal therapy, extensive restoration, periodontal (gum) treatment or crowns. I understand that removing teeth does not always remove existing infection and that further treatment may be necessary. I understand that the risks of removing teeth include, but are not limited to; pain, swelling, bleeding, infection, dry socket, fracture of bone or jaw, and loss of feeling in my lip or other facial areas, cheek, tongue, gums and teeth. Such numbness may be temporary or permanent. Also, there is the possibility of a small root piece being left in the jaw where the risks of removing it outweigh the benefits. I understand that further care by a specialist may be needed if complications arise during or after treatment, and that costs incurred are my responsibility.

____ 8. PERIODONTAL DISEASE: Periodontal disease can be a serious condition, causing gum and bone inflammation and/or loss and may lead to loss of permanent teeth. Possible treatment plans have been explained to me, including deep cleaning, gum surgery and bone grafting, extraction of teeth and tooth replacement. I understand that much of the success of periodontal treatment depends on my continuing home care and faithful adherence to following my doctor's instruction, including strict observance of recall appointments. I understand that care by a specialist may be necessary.

____ 9. ROOT CANAL THERAPY: I realize root canal therapy has a very high success rate; however, there is no guarantee that root canal treatment will save a tooth, and complications can occur. During the procedure some complications or conditions might be noticed which would require a referral to a specialist or extraction. These include; extensive decay making the tooth not restorable, perforations, a fractured tooth, curved or hardened canals, and extra canals whose presence couldn't be diagnosed earlier leading to persistent pain and infection. I understand that root canal files are extremely fragile instruments and may sometimes separate within the root, which may or may not affect success. Teeth exhibiting extensive infection where conventional root canal therapy is not enough might need further surgery or treatment by a specialist at additional costs to me. A small percentage of root canals fail despite the best efforts. I understand that specialty care may be indicated if complications arise and any costs incurred are my responsibility. After root canal therapy, a crown is usually needed which, if not placed right away, might lead to fracture of the tooth and possible extraction.

____ 10. CHANGES IN TREATMENT PLAN: I understand that during treatment it may be necessary to change or add procedures because of conditions discovered during treatment that were not evident during examination. I authorize my doctor to use professional judgment to provide appropriate care. I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed. I acknowledge that no such guarantees have been made regarding dental treatment I have authorized. I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment.

_____11. EMERGENCIES: In case of an emergency in which I am unable to communicate, I agree to allow Southern Trinity Health Services Provider(s) to give me standard emergency lifesaving care.

CONSENT: I have had the opportunity to have all my questions answered by my doctor, and I certify that I understand English. I consent to any dental services necessary or recommended by a Southern Trinity Health Services Provider, *upon which we mutually agree*. My signature below signifies that I understand the treatment and anesthesia that is proposed for me, together with the known risks and complications associated with that treatment. I hereby give my consent for the treatment I have chosen.

Patient's / Guardian's Signature _____Date _____

Witness' Signature _____ Date _____

Child Health/Dental History Form

American Dental Association
www.ada.org

Patient's Name (LAST / FIRST / INITIAL)	Nickname	Date of Birth
Parent's/Guardian's Name	Relationship to Patient	
Address (PO OR MAILING ADDRESS / CITY / STATE / ZIP CODE)		
Phone (Home / Work)		Sex M ❑ F ❑

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ❑ Yes ❑ No
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3.Cough that produces blood?
If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to, any of the following:

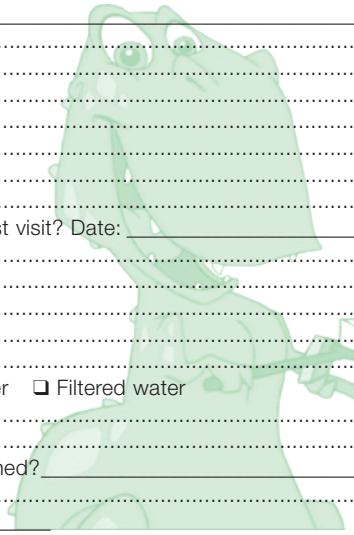
❑ Anemia	❑ Cancer	❑ Epilepsy	❑ HIV +/AIDS	❑ Mononucleosis	❑ Thyroid
❑ Arthritis	❑ Cerebral Palsy	❑ Fainting	❑ Immunizations	❑ Mumps	❑ Tobacco/Drug Use
❑ Asthma	❑ Chicken Pox	❑ Growth Problems	❑ Kidney	❑ Pregnancy (teens)	❑ Tuberculosis
❑ Bladder	❑ Chronic Sinusitis	❑ Hearing	❑ Latex allergy	❑ Rheumatic fever	❑ Venereal Disease
❑ Bleeding disorders	❑ Diabetes	❑ Heart	❑ Liver	❑ Seizures	❑ Other_____
❑ Bones/Joints	❑ Ear Aches	❑ Hepatitis	❑ Measles	❑ Sickle cell	

Please list the name and phone number of the child's physician:

Name of Physician _____ Phone _____

Child's History

		Yes	No
1.	Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: _____	❑	❑
2.	Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	❑	❑
3.	Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	❑	❑
4.	How would you describe the child's eating habits? _____		
5.	Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	❑	❑
6.	Has the child ever been hospitalized?	❑	❑
7.	Does the child have a history of any other illnesses? If yes, please list: _____	❑	❑
8.	Has the child ever received a general anesthetic?	❑	❑
9.	Does the child have any inherited problems?	❑	❑
10.	Does the child have any speech difficulties?	❑	❑
11.	Has the child ever had a blood transfusion?	❑	❑
12.	Is the child physically, mentally, or emotionally impaired?	❑	❑
13.	Does the child experience excessive bleeding when cut?	❑	❑
14.	Is the child currently being treated for any illnesses?	❑	❑
15.	Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	❑	❑
16.	Has the child had any problem with dental treatment in the past?	❑	❑
17.	Has the child ever had dental radiographs (x-rays) exposed?	❑	❑
18.	Has the child ever suffered any injuries to the mouth, head or teeth?	❑	❑
19.	Has the child had any problems with the eruption or shedding of teeth?	❑	❑
20.	Has the child had any orthodontic treatment?	❑	❑
21.	**What type of water does your child drink?** ❑ City water ❑ Well water ❑ Bottled water ❑ Filtered water		
22.	**Does the child take fluoride supplements?**	❑	❑
23.	**Is fluoride toothpaste used?**	❑	❑
24.	How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	❑	❑
25.	Does the child suck his/her thumb, fingers or pacifier?	❑	❑
26.	At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____		
27.	Does child participate in active recreational activities?	❑	❑



NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____ Date _____

For completion by dentist

Comments _____

For Office Use Only: ❑ Medical Alert ❑ Premedication ❑ Allergies ❑ Anesthesia Reviewed by _____

Date _____

Form S707

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or go online at www.adacatalog.org

Southern Trinity Health Services
Southern Trinity Area Rescue

Serving Southern Trinity & Southeastern Humboldt Since 1979

Dear Patient,

This letter is to inform you of your responsibilities regarding missed appointments.

According to our Missed Appointment Policy, the following steps are taken to ensure that all patients are aware and understand their responsibilities and rights regarding the occasional but sometimes necessary need to reschedule an appointment. An appointment where the patient does not appear or cancels with less than 24 hours' notice are both considered missed appointments for the purpose of our policy.

1) Southern Trinity Health Services makes reminder calls 48 and 24 hours before your appointment to allow you the opportunity to cancel an appointment.

2) All missed appointments will be recorded in your chart.

3) Missed appointments receive a follow-up call and letter notifying the patient of the recorded missed appointment.

Dental Policy

4) Dental patients will only be allowed two (2) missed appointments. At this time they will not be given the option to schedule appointments and will be required to call on a daily basis to see if an opening is available.

Medical / Behavioral Health Policy

5) Medical and behavioral health patients that miss more than three (3) visits within two (2) years will be reviewed and will only be considered for same-day appointments.

Patient Signature: _____

Date: _____

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