Adult Dental Clinic New Patient Packet

Our non-profit clinic provides free dental care to qualifying residents of Fairfield, Lexington and Richland counties. Our goal is to provide quality care to as many patients as possible, therefore we ask for your help to make your time spent with us productive.

ARRIVE PREPARED:

- Read the attached packet for eligibility
- Collect documentation of your proof to qualify
- Complete New Patient Packet prior to your arrival
- Complete Health History with accurate Information
- If a translator is needed, they must be over the age of 18 and accompany you to every appointment.

ARRIVE ON TIME:

Walk-in treatment times vary by location.

REMAIN AT THE CLINIC:

Be prepared to stay in the clinic for several hours. Take your medication as prescribed by your physician and have a nourishing meal prior to arrival. All patients are asked to remain in the clinic until their treatment is complete. The doctor will see you as soon as possible.

For their safety, do not bring children to the clinic.

WellPartners Adult Dental Clinic Richland County Health Department 2000 Hampton Street, Suite 3145 Columbia, SC 29204 Phone: 803.888.1690 Clinic Hours of Operation: Monday—Thursday 8:00 A.M.—4:30 P.M. Friday 8:00 A.M.—12:00 P.M. ***Contact the location for treatment times***	**WellPartners Adult Dental Clinic** Lexington County Health Department Red Bank Crossing 1070 South Lake Drive, Suite B Lexington SC 29073 Phone: 803.888.3270 Clinic Hours of Operation: Monday 8:00 A.M.—4:00 P.M. Tuesday 12:30 P.M.—4:00 P.M. Thursday 12:30 P.M. —5:00 P.M. ***Contact the location for treatment times***

ADULT DENTAL CLINIC

SCREENING CHECKLIST FOR ELIGIBILITY

To meet eligibility, you must provide the clinic with following items at your FIRST VISIT:

1. **ADULT REFERRAL PACKET:**
   - **completely and accurately filled out and signed**
   - **If a translator is needed, they must be over the age of 18 and accompany you to every appointment.**

2. **SOUTH CAROLINA PHOTO IDENTIFICATION:**
   - **Valid SC ID or driver's license**

3. **DOCUMENTATION TO VERIFY PATIENT ELIGIBILITY:**
   - **18 years or older (your license or ID)**
   - **A resident of Fairfield, Lexington or Richland County (your license or ID)**
   - **Low income (≤ 200% of poverty level)**
   - **No dental insurance**

YOU MUST PRESENT AT LEAST ONE TO VERIFY LOW INCOME AND NO DENTAL INSURANCE: The following are examples of acceptable documentation to verify your eligibility.

- **Check stub(s) for patient seeking treatment**
- **W-2 form**
- **Proof of Military Service**
- **Medicaid card or verification of SNAP benefits (EBT card)**
- **Verification of Social Security income, SSI Disability, VA pension or retirement income**
- **If you do not work but live in the household with someone that receives any of the above, their income must be verified with above.**
- **If you live in a household and someone else pays your expenses, you must provide a written statement: specify the amount paid monthly, signed by both you and the person paying expenses.**

ADULT DENTAL CLINIC

REGISTRATION AND HEALTH HISTORY

PERSONAL INFORMATION: **Date: _____**

Name: _____ _____	**Home Address:** _____ _____ _____ **Phone #:**_____	**Work Address:** _____ _____ _____ **Phone #:**_____	**SC Driver's License: Yes or No #:** **SC Identification: Yes or No #:**
Social Security #: _____	**Date of Birth:**_____	**Occupation:** _____ _____	**Medicaid: Yes or No #:** **Medical/Dental Insurance: Yes or No**
Education: circle one Elementary High School College Masters/Doctorate **Military Service:** ○ Army ○ Army Reserve ○ Army National Guard ○ Marine Corps ○ Marine Corps Reserve ○ Navy ○ Navy Reserve ○ Air Force ○ Air Force Reserve ○ Air National Guard ○ Coast Guard ○ Coast Guard Reserve	**Race: circle one** Asian Black Hispanic/Latino Native American White Other **Who may we thank for referring you to our office?** ○ Eau Claire Cooperative Health ○ Richland County/ Lexington County DHEC ○ United Way of the Midlands ○ Prisma Health ○ Lexington Medical Center ○ Free Medical Clinic ○ MUSC **How did you hear about WellPartners:** _____	**Sex: circle one** Male Female **Marital Status: circle one** Single Married Widowed Divorced **Preferred Pro-Nouns:** _____	**Your Physician:** **Name and Address or Phone #:** _____ _____ _____ _____ **Date of last visit:**_____ **Treated for:**_____ _____ _____ **Date of last physical:** _____ **Your Height:** _____ **Your Weight:** _____
EMERGENCY Contact: Name:_____ Phone #: _____	**Closest Relative:** Name: _____ Phone #:_____	**Name of last Dentist:** _____ **Date of last visit:** _____ **Treated for:**_____ _____ _____	**Have you used the emergency room for dental problems:** **Date of last visit:** _____ **Treated:** _____ _____

MEDICAL INFORMATION

LIST YOUR CURRENT MEDICATIONS HERE (or give written list to clinical staff): _____

_____
_____
_____
_____
_____
_____
_____

PLEASE TAKE YOUR PRESCRIBED MEDICATIONS AS DIRECTED PRIOR TO COMING TO CLINIC

CHECK BOXES **ANSWER ALL QUESTIONS THAT APPLY.**

YES	NO	
		Are you taking any medications?
		Are you **allergic** to any medications?
		Have you been seriously ill in the last **five** years?
		Have you ever been hospitalized or had a serious illness?
		Have you been informed by a physician that you need to be pre-medicated for dental treatment? Circle reason: **Artificial Heart Valve** **Artificial Joint** Other:_____
		Do you have a persistent cough?
		Have you resided or worked with anyone who has had tuberculosis?
YES	NO	↓ **QUESTIONS BELOW FOR WOMEN** ↓
		Are you pregnant? If so, what month?
		Are you taking birth control pills?
		Are you in or have you been through menopause?
		Are you or have you taken medication for osteoporosis?

Name_____ Date_____

CHECK BOXES **DO YOU HAVE, OR EVER HAD, ANY OF THE FOLLOWING CONDITIONS?**

YES	NO		YES	NO	
		AIDS/HIV positive			Heart Trouble or Murmur
		Allergies: list_____ _____ _____			Heart Attack: date_____
		Anemia: type_____ _____			Hepatitis: type_____ Date_____
		Arthritis/Rheumatism			High Blood Pressure (hypertension) Low Blood Pressure (hypotension)
		Bleeding Disorders			Hives or Skin Rash
		Blood Disease			Kidney Disease
		Blood Transfusion			Liver Disease
		Cancer or Tumor: type—			Osteoporosis Joint Replacement: date_____

		Chemotherapy/Radiation: date—			Psychological Problems
YES	NO		YES	NO	
		Chest Pains (angina)			Rheumatic Fever/Rheumatoid Heart Disease
		Contact Lenses			Sinus Trouble
		Cortisone/Steroid treatment			Shortness of Breath
		Diabetes (sugar disease): circle type type 1 (insulin) type 2 (diet controlled)			Heart Valve, Heart Stent, Pacemaker Date—
		Drug/Alcohol addiction			Stomach/Intestinal Disease (ulcers)
		Drug Reaction			Stroke
		Epilepsy (seizures) or Paralysis: Type—			Swelling of hands or feet
		Eating Disorder: Type—			Thyroid Disease
		Fainting (frequent)			Tuberculosis (TB)
		Headaches (frequent)			Lung Disease - Emphysema
		Head Injury: date –			

Other condition(s) the doctor should be aware of prior to your care:

_____

IN THE <u>PAST TWO YEARS</u>, HAVE YOU TAKEN ANY OF THE FOLLOWING MEDICATIONS?

YES	NO		YES	NO	
		Antibiotics (Penicillin, Zithromax Z-pak, INH, Rifampin, Tetracycline, etc.)			Insulin (diabetes medication)
		Anticoagulants (blood thinners: Coumadin, Plavix, etc.)			High blood pressure medication: List—
		Pain or anti-inflammatory medication (Cortisone steroid injections, Prednisone)			Heart medication (Digitalis, Nitroglycerin, etc.) List—
		Non-steroid drugs (Aspirin, Ibuprofen, Advil, etc.)			Osteoporosis medication (Fosamax, Boniva, Hormone replacement meds.)
		Antihistamines (Benadryl, etc.)			Tranquilizers or sleep aids: list—
		Sulfa Drugs			

Name_____ Date_____

CHECK BOXES **ARE YOU ALLERGIC TO, OR HAD AN ADVERSE REACTION TO, ANY OF THE FOLLOWING:**

YES	NO		YES	NO	
		Antibiotics (penicillin, tetracycline, etc.)			Sulfa drugs
		Barbiturates (sleeping pills, sedatives, etc.)			Local anesthetics
		Iodine			Latex
		Narcotics (codeine, etc.)			Other:

DENTAL INFORMATION

CHECK BOXES **DO YOU HAVE, OR EVER HAD, ANY OF THE FOLLOWING DENTAL CONDITIONS?**

YES	NO		YES	NO	
		Severe dental pain			Do you brush your teeth less than twice a day?
		Fear of the dentist or dental treatment			Do you floss your teeth less than once a day?
		Grinding or frequent clenching of teeth			Have you ever been told you have gum disease?
		Pain when opening or closing mouth			Have you ever had periodontal (gum) surgery?
		Unpleasant taste or order in your mouth			Date of last dental cleaning:
		Bleeding gums when brushing/flossing			Have you noticed any shifting teeth?
		Swelling			Have you ever worn braces?
		Prolonged bleeding after tooth extraction?			Do you have sensitivity to hot, cold, or sweets?
		Adverse (bad) reaction to dental anesthesia (Novocain)			Have you noticed any discoloration or unusual conditions of your teeth, gums, or mouth tissue?
		Tobacco Use - MAY LEAD TO DENTAL CONDITIONS: Smoke? # of packs_____ Chew? _____ Frequency_____			Other:_____ _____ _____

Signature_____ Date: _____

ADULT DENTAL CLINICS

POLICIES AND PROCEDURES

***Adult patients are defined as 18 years or older.**

***No children are allowed in the clinic during adult clinic hours.**

***Adult patients must bring eligibility documentation as previously described in Screening Checklist.**

***Patients must live in Fairfield, Lexington or Richland County and seek treatment at the clinic in which they reside.**

Lexington County Residents	Fairfield and Richland County Residents
Location: WellPartners Lexington County Health Department Red Bank Crossing 1070 South Lake Drive, Suite B Lexington, SC 29073 Phone: 803.888.3270	Location: WellPartners Richland County Health Department 2000 Hampton Street, Suite 3145 Columbia, SC 29204 Phone: 803.888.1690
Parking: Free	Parking: Public metered parking; bring change for the meter
Clinic Hours (not treatment times): Monday: 8:00 A.M. – 4:00 P.M. Tuesday: 12:30 P.M. – 4:00 P.M. Thursday: 12:30 P.M. – 5:00 P.M.	Clinic Hours (not treatment times): Monday –Thursday: 8:00 A.M. – 4:30 P.M. Friday: 8:30 A.M. – 12:00 P.M.
Please, plan to be here several hours. The doctor will see you as soon as possible.	
Clinic Closures: The clinics observe all county holidays when the building is closed. Notice will be posted for other closures.	

ADULT DENTAL CLINICS

POLICIES AND PROCEDURES continued

Our Dental Clinic is designed primarily for **basic** preventive treatment, restorative treatment, and emergency care. These services will be provided as long as funding is available. **Dental Emergencies** are defined as **oral pain, infection, or trauma.**

Procedures Provided:
Eligibility/Emergency Exam and Screening
Radiographs (x-rays)
Basic dental cleaning (once a year)
Basic restorative treatment (fillings)
Simple & Uncomplicated Surgical Extractions

Procedures Not Provided:
Root Canals
Crowns/Bridges
Dentures/Partials
Complicated Surgical Extractions
(Wisdom Teeth, Impacted Teeth or Roots)
Periodontal Scaling and Root Planing

No Sedation:
Nitrous oxide, known as "laughing gas" is not available in any of our Dental Clinics

****No Comprehensive Exams:**
Due to limited time and resources, detailed dental examinations are not available for: medical procedures dental clearance for surgery military dental clearance comprehensive periodontal examinations

Dentist reserves the right to refuse or postpone treatment:
Patient is disruptive or under the influence (alcohol or drugs of any kind).
Patient has a complicated or high risk medical history requiring treatment in an acute
Care facility (hospital or an oral surgeon).
Patient has infection which may prevent proper anesthesia.
Patient has a complicated procedure which requires specialist.

I have read or someone has read the policies of this program to me. I understand the policies and procedures and give permission for myself to be treated by the dentist and /or hygienist employed by the Community Partners of the Midlands, LLC, WellPartners Adult Dental Clinics.

Signature/Mark of Patient Date