Welcome to Treasure Coast Community Health's Dental Department!

It is a pleasure to welcome you to our dental practice and we want you to know that we appreciate the opportunity to take care of your dental needs. We strive to help all of our patients achieve a healthy dental condition. Your care starts with a thorough exam and x-rays that our dentist deems appropriate to help diagnose your dental health and develop a treatment plan for you.

TCCH comprehensive dental program offers patients the following services: dental education, dental hygiene care, limited periodontal care (scaling and root planing), preventative care (i.e., sealants), restoration (fillings), removable partials and dentures, and extractions (surgical and non-surgical) on both adults and children.

Please be advised that after any of the following exams – new patient, periodic, emergency or consultation – that some or all of your recommended dental treatment may not be able to be performed at TCCH should it be considered "out of the scope of our practice". This includes, but is not limited to, the patient's desire for procedures or treatments such as: dental implants, root canals, crowns and or fixed bridgework, veneers, orthodontics or treatment requiring IV sedation.

Patients of TCCH's Dental Department are required to agree to these Standards of Care:

1. TCCH dental providers will make treatment recommendations based on the best clinical judgment, as to the standard of care perimeters which may include: type of dental hygiene procedures required; extraction(s) of teeth; type of dental materials used for fillings, and or removable partials or dentures and use of certain types of fluorides. This may include a referral to see a dental specialist(s) outside of the TCCH.

2. TCCH dental providers determine the sequence of dental treatments and next appointment(s). Patient desires will be considered where possible. However, you and your dental provider will agree upon a Treatment Plan based on priorities of your dental needs and possible consequences of delaying treatment.

3. A Treatment Plan Coordinator will meet with you to review your treatment plan, answer your questions and to schedule your appointments according to your individual needs.

4. A patient who has not had an exam for 2 years at TCCH's dental center will require a new comprehensive exam before any hygiene or non-emergency treatments.

5. Patients who are "walk-ins" will be seen in the order as the dental center deems is the most appropriate and not who necessarily arrive first. Emergency patients will be evaluated; x-ray films will be taken as deemed appropriate by the dental provider. No dental procedures can be guaranteed that day.

6. A patient who was seen at a TCCH dental office as an emergency only patient (or has a history of emergency exam visits) will not be considered as a patient for continuity of care.

7. Your dental and medical health is our first priority at TCCH. Many times a medical condition can affect your dental treatments. Therefore, TCCH requires your recent medical records from your primary care physician. If you do not have a primary care physician we would be happy to establish medical care with one of our TCCH Medical Physicians.

8. If a medical clearance is required for treatment at TCCH, it is your responsibility to obtain the medical clearance from your Physician and return to TCCH. TCCH will be unable to see you for your appointment without this paperwork.

9. If you are seeking a dental clearance that is required promptly for a medical procedure, TCCH is unable to guarantee it. You will need to seek dental clearance elsewhere if needed quickly.

10. Dental No Show/Cancellation Policy: Patients who need to cancel their appointment must do so at least 24 hours prior to their appointment or it will be considered a No Show. Patients (Head of household or guarantor) that have more than 2 No Shows within the past 12 months will not get another appointment for 1 year.

Sincerely,

Kim Platt
Dental Manager

TREASURE COAST COMMUNITY HEALTH, INC.
(772) 257-TCCH (8224)

FELLSMERE
12196 County Road 512
Fellsmere, FL 32948

SOUTH VERO
1545 9TH St SW (Oslo Road)
Vero Beach, FL 32962

VERO
1955 21st Avenue
Vero Beach, FL 32960

Medical History:

Patient Name: Date of Birth:

CHECK ALL ITEMS THAT APPLY TO YOUR HISTORY

	ADHD/ADD
	Syncope (Fainting)
	Anxiety Disorder
	Alzheimer's/Parkinson's
	Arthritis
	Artificial Joint Replacements
	Asthma
	Bleeding-Excessive
	Blood Disease
	Bone Disease
	Brain Stimulation Device (DBS)
	Cancer
	Central Nervous System Disorder
	Chronic Pain Management
	Obstructive Lung Disease (COPD)
	Lung Problems - Other
	Developmentally Challenged
	Kidney Dialysis
	Organ Transplant-Lung, Kidney, Liver, Pancrease, Bone Marrow (Cirlce)
	Diabetes Type 1 (Insulin)
	Diabetes Type 2 (Oral Medication)
	Eating Disorder
	Emphysema
	Thyroid, Parathyroid, Adrenal, Pituitary Problems
	Eye Disorder
	Injury to: Face, TMJ, or Jaw
	Stomach/Intestine Disorder
	Gout
	Hearing Impaired
	Heart Pain-Angina
	Heart Attack (M.I.): Dates:
	Heart Stent(S): Dates:
	Heart Disease
	Heart Infection (Endocarditis)
	Pacemaker or Defibrillator
	Heart Surgery: Dates:
	Artificial Heart Valve (Circle): Tissue or Mechanical

	Heaptitis A, B, or C: DATE:
	High Blood Pressure
	Low Blood Pressure
	HIV/AIDS: DATE:
	Immune System Disorder: DATE:
	Kidney, Liver, or Pancreatic Disease
	Lupus
	Mental Disorder
	Multiple Myeloma
	Osteoporosis
	Cebrebal Palsy
	Autism
	Post Traumatic Stress Disorder
	Radiation to Head, Jaws, or Neck
	Severe Nightmares
	Sleep Apnea (Snoring)
	Seizure Disorder
	Sexually Transmitted Disease
	Substance Abuse: Alcohol, Drugs, Other
	Surgery - Other
	Stroke
	Sinus Problems
	Speech Problems
	TMJ Problems
	Thrombo Embolism
	Tobacco Use
	Tumors
	Ulcers
	Vascular Surgery

FEMALES:

	Pregnant Now
	Nursing Now
	Trying to get Pregnant
	Taking Fertility Drugs
	Practicing Birth Control

PAGE 1 - TURN OVER

NOW TAKING MEDICATION FOR ANY OF THE FOLLOWING CONDITIONS (CHECK & CIRCLE):

	ADHD/ADD		Depression
	Allergies		Sedatives or Sleep Aids
	Adrenal, Thyroid, Parathyroid, or Pituitary Gland Problem		Fertility
	Birth Control		Cholesterol Management
	Pain-Codeine, Percocet, Tramadol, Morphine, Demerol, or Pain Patch		Anti Inflammatory - Prednisone, Cortisone
	Osteoporosis		Chronic Pain Management
	Pain - Ibupropehn, Motrin, Celebrex		Diabetes Type 1
	Cancer - Radiation Treatment		Diabetes Type 2
	Cancer - Medication		Ulcers, Stomach or Intenstinal Problems
	Cancer Involvement of Bones		Hepatitis
	Blood Thinners - Coumadin, Pradaxa, Heparin		HIV/AIDS
	Blood Pressure Regulation		Hormone - Estrogen
	Anti Platelet/Clotting - Plavix, Aspirin		Non Prescription Street Drugs
	Aspirin 325mg		Immune Suppresive Drugs
	Aspirin 81mg		Kidney, Urinary, Prostate Problems
	Alzheimer's or Parkinson's		Multiple Sclerosis
	Anti-Seizure		Multiple Myeloma
	Anxiety		Plasma Products or Blood Factors
	Bone Problems		Heart Rhythm Problems
	Breathing Problems - Oxygen Therapy		**EVER TAKE ANY OF THE FOLLOWING?(CIRCLE & CHECK)**
	Breathing Problems - Inhalers		Actonel, Aredia, Boniva, Fosomax, Zometa (Notrogen Conaining Bisphosponates)
	Heart Problems		Atelvia, Didronel, Reclast, Skelid (Non-Nitrogen Containing Bisphosphonates)

HAVE YOU EVER HAD ALLERGIES TO:

	Any Foods:		Barbituates, Sedatives, or Sleeping Pills
	Local Anesthetics (such as Novacain, Ldiocaine, Mepivicaine, etc.) Other:		Penicillin, Amoxicilllin, Ampicillin, Augmentin (Penicillin Family)
	Erythromycin		Narcotics: ☐Hydocodone
	Tetracycline:		Oxycodone ☐ Demerol ☐Other
	Zithromax (Azithromycin)		Acetaminophen (Tylenol)
	Cipro		Aspirin
	Clindamycin		Aleve
	Metals:		Codeine
	Latex (Rubber)		Tramadol
	Keflex (Cephalosporin Family)		Sulfa Drugs
	Ibuprofen - (Motrin, Advil or Generic Ibuprofen)		Other Drugs
	Name of any other antibiotic allergy:		Hay Fever/Seasonal
	Barbituates, Sedatives or Sleeping Pills		Other
	Iodine		

All of the answers above are true and correct. If I have any changes in my Health or my Medications, I will notify the Doctor at my next appointment without fail.

Patient/Guardian Signature: **DATE:**

Dental History

Name: _____ Date of Birth: _____

Height: _____ Weight: _____

Who is your primary doctor? _____

Are you being treated by a Physician for any reason at present? **Yes** ☐ **No** ☐
Reason for treatment? _____

_____

Are you experiencing pain from your mouth at this time? _____

Ever had swollen or bleeding gums? _____

Ever noticed any loose teeth? _____

Ever had injury to your face, jaws, or teeth? _____

Have you ever had gum (periodontal) treatment? _____

Have you ever had braces to straighten teeth? _____If so, for how long? _____

Have your teeth been replace by a ☐Fixed Bridge ☐Removable Partial ☐ Other_____

Does your jaw click when you chew or open your mouth? _____

Do you have pain in the ☐ Jaws ☐ Ears ☐ Temples ☐ Neck
Is this pain present on awakening? _____

Ever have prolonged bleeding following a tooth extraction? ☐**Yes** ☐**No**

Reasons for past extractions: ☐ Decay ☐ Loose Teeth ☐ Accident ☐ Infection

Ever had: ☐ Canker Sores ☐ Cold Sores ☐ Mouth Ulcers
If yes, then how often? _____

When was your last full mouth x-ray series taken? Date: _____

Tell us about your previous dental experiences: _____

_____

_____

Consent to Routine Dental Treatment

Patient Name:_____ Date of Birth: _____

1. I hereby request and authorize TCCH provider, and/or such other persons as he may appoint, to perform or assist in the performance of dental treatment for one or more of the following conditions:

Dental Decay	Gingivitis	Periodontitis	Trauma
Dental or Gingival Abscess	Mouth Sores or Lesions	Malocclusion	Oral Cancer
TMJ Problems	Irreversible Pulpitis	Acute Pulpitis	Broken Tooth

Other: _____ Other: _____ Other: _____

Other: _____ Other: _____ Other: _____

2. I understand that unforeseen conditions or circumstances may arise during the course of the above described procedure or treatment; hence, I consent to and authorize the performance of any care, procedure, or treatment not specified above that the dentist reasonable believes necessary or advisable as a result of these unforeseen events.

3. Additionally, I consent to the administration of any local anesthetic or analgesic (Nitrous Oxide) that the dentist deems necessary, I understand that the risks involved with the administration of local anesthetics include, but are not limited to:
   A. Nerve injury causing temporary or permanent numbness of the lower lip, chin, and tongue area
   B. Infection
   C. Stiffness of the jaw (Trismus)

4. I understand that a perfect result is not guaranteed or warranted and cannot be guaranteed or warranted.

_____ _____
Patient's Signature Date

_____ _____
Parent/Legal Guardian Date

_____ _____
Witness (TCCH Staff) Date