SMILE. CHEW. LIVE.

Arizona Community Dental Clinic

If you are currently experiencing pain or infection, especially swelling, visit your healthcare provider or emergency room <u>immediately</u> for appropriate medication as we are unable to provide a timely response.

Thank you for contacting the Arizona Community Dental Clinic about your oral health problems. The Dental Urgent Care Clinic is designed to meet the needs of seniors; individuals with a special or medical need; and working poor families whose income falls at 200% of the federal poverty level or less. If you are unsure of your status see the chart on the back of the financial qualifier.

Complete the enclosed financial qualifier and health history and return both forms to us by mail. ***<u>Once we receive your application it may take up to 18 months before you will be scheduled for an appointment.</u>*** On your first visit you will be required to show proof of income by presenting your AHCCCS/Medicaid card, SNAP eligibility, SSDI verification, and/or payroll stubs from within the last three months. Your first visit will consist of x-rays and an exam. The dentist will discuss treatment planning with you at that time.

If you require a dental appliance like dentures, partial, or crown(s), you are required to pay dental laboratory costs and a minor processing fee in advance. An additional fee may also be required for more extensive procedures like a root canal or biopsy.

This clinic is not designed for "smile make-overs" or implants. This clinic is designed to eliminate pain and return your mouth to healthy function.

- ACDC does not accept insurance or AHCCCS at this time.
- ACDC does not provide sedation services at this facility.

Please be patient as we attempt to build a full-service community clinic to respond to the dental needs of vulnerable citizens in the Phoenix Metro area.

Arizona Community Dental Clinic • 1150 E Washington • Phoenix, AZ 85034
acdcdental.org • 602-254-DUCC (3822) • voicemail

Rvsd 6/12/14

Arizona Community Dental Clinic
Financial Qualifier

Name:____ Date of Birth: ______________________

Address:_______________________________________ Phone:__________________________

City, State, Zip:____

Emergency Contact Name & Number: ____

Complete for entire household income. Number of people in your household:_______________

Name of each person Age Relationship to you

____

____

____

____

Are you able to work? ❑ yes ❑ no If no, please explain:____________________________________
Are you a Veteran? ❑ yes ❑ no Are you homeless? ❑ yes ❑ no
Do you receive Medicaid/AHCCCS? ❑ yes ❑ no Do you receive Medicare? ❑ yes ❑ no

HOUSEHOLD MONTHLY INCOME		HOUSEHOLD MONTHLY EXPENSES	
$ /Month	Your Wages	$ /Month	Housing (rent/mortgage)
$ /Month	Spouse's Wages	$ /Month	Phone
$ /Month	Food Stamps	$ /Month	Food (not including SNAP)
$ /Month	Unemployment	$ /Month	Utilities (Gas/Electric/H20/Sewer)
$ /Month	Social Security	$ /Month	Car Payment
$ /Month	Social Security Disability	$ /Month	Car Insurance
$ /Month	WIC	$ /Month	Vehicle Gas
$ /Month	Other	$ /Month	Health Insurance
		$ /Month	Medications
		$ /Month	Out of Pocket Medical Costs
		$ /Month	Life/Burial Insurance
		$ /Month	Other
$ /Month	TOTAL	$ /Month	TOTAL

$ ___________ Total value of savings
$ ___________ Total value of investments/Type of investments:________________________________
Use this space to elaborate on any information not sufficiently explained above:

____

Referral Source: ____
(Optional) Name of Caseworker: ____

You must complete an application for each person that is requesting dental services.

2017 Federal Poverty Guidelines

This table shows the federal poverty level for each family size with percentage columns that represent income levels that are commonly used as guidelines for health programs.

Household Size	< or = 100%	100%	150%	200%
1	For seniors 65+ and individuals of any age covered by ALTCS/EPD	12,060	18,090	24,120
2		16,240	24,360	32,480
3		20,420	30,630	40,840
4		24,600	36,900	49,200
5		28,780	43,170	57,560
6		32,960	49,440	65,920
7		27,140	40,710	54,280
8		41,320	61,980	82,640

Acceptable proof of eligibility:

- Medicaid card
- SNAP (food stamps) card
- Social Security Disability Insurance
- Most recent payroll stub (within the last three months)

Individuals earning above these limits will be referred to an AzDA member dentist.

Children covered by AHCCCS will be referred to a community clinic.

No shows will be charged $25 without 24-hour notice of cancellation

New patients with two no shows will be moved back on the waiting list

Additional costs may apply for additional teeth, laboratory work, or specialized care.

rvsd 2/16/2017

Arizona Community Dental Clinic
Health History (Page 1 of 2)

Print Patient Name ___________________________________ Birth Date ______________ ❑ M ❑ F

Allergies (drugs, food, latex) ____

Check the appropriate answer (leave blank if you do not understand the question)

❑ Yes ❑ No Is your general health good?
❑ Yes ❑ No Has there been a change in your health within the last year?
❑ Yes ❑ No Have you been hospitalized or had a serious illness in the last year?
If YES, explain, ____
❑ Yes ❑ No Have you been hospitalized or had a serious illness in the last three years?
If YES, explain, ____
❑ Yes ❑ No Are you being treated by a physician now? Why? ______________________________
____ Date of last medical exam __________________
Date of last dental exam ______________________ Date of last dental x-rays __________________
❑ Yes ❑ No Have you had problems with prior dental treatment?

HAVE YOU EXPERIENCED …?

❑ Yes ❑ No Chest pain (angina)
❑ Yes ❑ No Swollen ankles
❑ Yes ❑ No Shortness of breath
❑ Yes ❑ No Recent weight loss, fever, night sweats
❑ Yes ❑ No Persistent cough, coughing up blood
❑ Yes ❑ No Bleeding problems, bruising easily
❑ Yes ❑ No Sinus problems
❑ Yes ❑ No Difficulty Swallowing
❑ Yes ❑ No Diarrhea, constipation, blood in stools
❑ Yes ❑ No Frequent vomiting, nausea
❑ Yes ❑ No Difficulty urinating, blood in urine
❑ Yes ❑ No Dizziness
❑ Yes ❑ No Ringing in ears
❑ Yes ❑ No Headaches
❑ Yes ❑ No Fainting spells
❑ Yes ❑ No Blurred vision
❑ Yes ❑ No Seizures
❑ Yes ❑ No Excessive thirst
❑ Yes ❑ No Frequent urination
❑ Yes ❑ No Dry mouth
❑ Yes ❑ No Jaundice
❑ Yes ❑ No Joint pain, stiffness

DO YOU HAVE OR HAVE YOU HAD …?

❑ Yes ❑ No Heart disease
❑ Yes ❑ No Heart attack, heart defects
❑ Yes ❑ No Heart murmurs
❑ Yes ❑ No Rheumatic fever
❑ Yes ❑ No Stroke, hardening of arteries
❑ Yes ❑ No High blood pressure
❑ Yes ❑ No Asthma, TB, emphysema, lung disease
❑ Yes ❑ No Hepatitis, other liver disease
❑ Yes ❑ No Stomach problems, ulcers
❑ Yes ❑ No Family history of diabetes, heart problems, tumors
❑ Yes ❑ No AIDS
❑ Yes ❑ No Tumors, cancer
❑ Yes ❑ No Arthritis, rheumatism
❑ Yes ❑ No Eye diseases
❑ Yes ❑ No Skin diseases
❑ Yes ❑ No Anemia
❑ Yes ❑ No VD (syphilis or gonorrhea)
❑ Yes ❑ No Herpes
❑ Yes ❑ No Kidney, bladder disease
❑ Yes ❑ No Thyroid, adrenal disease
❑ Yes ❑ No Diabetes

Please complete both sides of this form

DO YOU HAVE OR HAVE YOU HAD …?

❑ Yes ❑ No Psychiatric care
❑ Yes ❑ No Radiation treatment
❑ Yes ❑ No Chemotherapy
❑ Yes ❑ No Prosthetic heart valve
❑ Yes ❑ No Artificial joint
❑ Yes ❑ No Hospitalization
❑ Yes ❑ No Blood transfusion
❑ Yes ❑ No Surgeries
❑ Yes ❑ No Pacemaker
❑ Yes ❑ No Contact lenses

WOMEN ONLY

❑ Yes ❑ No Are you or could you be pregnant or nursing?
❑ Yes ❑ No Taking birth control or hormone replacement therapy?

ALL PATIENTS

❑ Yes ❑ No Do you have any other disease or medical problems NOT listed on this form?
If YES, explain, ____
____

ARE YOU TAKING …?

❑ Yes ❑ No Recreational drugs
❑ Yes ❑ No Over the counter supplements or natural remedies including aspirin.
❑ Yes ❑ No Tobacco in any form
❑ Yes ❑ No Alcohol
Frequency ________________

LIST CURRENT MEDICATIONS (include strength and frequency)

ETHNICITY (Optional for demographic purposes but may provide value to your medical assessment)

❑ Asian ❑ African American ❑ Hispanic/Latino ❑ Native American/Native Alaskan
❑ Pacific Islander/Native Hawaiian ❑ White ❑ Other ethnicity - please specify ______________

WHAT ARE YOUR DENTAL PROBLEMS/NEEDS?

____
____
____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my provider of any change(s) in my health and/or medication during future visits.

Patient signature ________________________________ Date ___________________________