Declaration Reference and Key Data
Obligation Section Number: **5.07(c)(iii)**

Obligation Title: **Mobile Dental Center for Pre-School Children**

Obligation Page Number: **52**

Obligation Trigger: **Acquisition by ESD or CU of all Initial Stage 1 Condemnation Parcel(s)**

Obligation Start Date: **March 12, 2012**

Obligation End Date: **March 12, 2037 (25 Years from Commencement)**

Obligation Status: **In Compliance**

Obligation: Innovation/Changed Conditions
In accordance with the Declaration of Covenants and Restrictions Section 5.08, Obligation 5.07 (c)(iii) is modified to clarify the obligation. In general, the scope of services to be provided has not been changed. Empire State Development and Columbia University agreed to this modification on November 28, 2018.

Modified Language:
Mobile Dental Center for Pre-School Children. Commencing with the acquisition by ESD or CU of all Initial Stage 1 Condemnation Parcels, and continuing for a 25-year period commencement, CU shall extend its Mobile Dental Center to service pre-school children and seniors from the Manhattanville in West Harlem area. CU's College of Dental Medicine operates a mobile Dental Center. It is fully equipped with two dental operatories, x-ray equipment, waiting/oral health education area and handicapped accessible chairlift. The Mobile Dental Center is staffed with a dentist, pediatric resident, dental hygienist, dental assistant, and driver/data entry clerk. The Center currently travels to over 50 local Day Care and Head Start centers throughout northern Manhattan during the school year offering children ages 3-5 years comprehensive dental care. Parked adjacent to the host site two or more times per month, follow-up appointments are made every six months. Children requiring specialty services are referred to affiliated Community DentCare or Children's Aid Society dental clinics located throughout Washington Heights/Inwood and Harlem. CU's partnership with Alianza Dominicana facilitates enrollment into Medicaid or Child Health Plus for the uninsured.

Alternatives Based on Changed Conditions
While the Declaration states the Mobile Dental Center shall service pre-school children and seniors, dental services for seniors are offered through the ElderSmile program as reflected in the next commitment under Section 5.07(c)(iv).

The Columbia University College of Dental Medicine Community DentCare program partners with neighborhood organizations to provide health screenings and dental services at sites around Northern Manhattan and the South Bronx. The Mobile Dental Center focuses on pre-school children. The ElderSmile Program focuses on seniors. Services continue to be provided within the catchment area defined in the commitment overview above. Visits to each host site by the mobile health clinics are scheduled in coordination with leadership of each host site. The frequency of visits is determined in collaboration with each site based on site availability and preference. Follow-up appointments are made in accordance with each individual patient's dental requirements and in coordination with each site.

Evidence of Compliance

1. Link to website
2. Annual report

Columbia University's Implementation Plan and all supporting documentation are made available on the Columbia Neighbors Webpage at https://neighbors.columbia.edu/content/community-commitments.

EOC Checklist for Obligation 5.07(c)(iii):

Please check to verify EOC items submitted for review.

☐ 1. Link to website

☐ 2. Annual report

Monitor's Notes / Comments:

Status:
Please check to indicate the status of Obligation 5.07(c)(iii):

☐ In Compliance

☐ In Progress

☐ Not In Compliance

☐ Not Triggered

Mobile Dental Center for Pre-School Children

Link to website:

https://www.dental.columbia.edu/about-us/community-outreach/community-dentcare-program

COLUMBIA UNIVERSITY IRVING MEDICAL CENTER

We are open for dental care. Learn more about our services and how we are keeping our patients and employees safe.

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Community DentCare Program

Bringing Care to the Community

Many members of our community face barriers to accessing dental care and other health care. Recognizing this, Columbia University College of Dental Medicine launched its Community DentCare program in 1996 to help address these disparities, with special focus on children and the vulnerable elderly. We partner with around 70 neighborhood organizations to provide health screenings and dental services at sites around Northern Manhattan and the South Bronx. DentCare offers these services regardless of ability to pay.

DentCare has so far logged more than 150,000 patient care visits.

How We Work

Columbia fosters relationships with community partners—collectively called the Community DentCare Network—to coordinate visits to their locations. Partners include Head Start centers, schools, foster care facilities, senior citizen and community centers, and child care centers. Dental faculty, hygienists, and trainees provide care onboard our Mobile Dental Center or directly on site.

Mobile Dental Center

DentCare operates a 35-foot-long mobile clinic outfitted for comprehensive dental care and oral

Annual Report: Mobile Dental Center for Pre-School Children

State Submission Annual Reporting Period: **October 2022 - September 2023**

On April 11, 2023, Columbia University College of Dental Medicine launched a new Mobile Health Clinic, generously funded by a grant from the Mother Cabrini Health Foundation. The new mobile clinic is staffed by faculty and students at Columbia University's College of Dental Medicine and the Vagelos College of Physicians and Surgeons. Using an integrated model for both primary medicine and oral health that allows patients to receive comprehensive care, the van features both a dental chair and a medical examination table. The clinic is equipped to offer a new level of interdisciplinary preventive care, including vaccinations.

Like the current mobile clinic, which was funded by grant from Delta Dental, the new van services neighborhood schools, Head Start programs, daycare centers, foster care facilities, schools, nursing homes, rehabilitation centers, and health clinics in Harlem, Inwood, Washington Heights, and the South Bronx to provide onsite oral health care and preventive health services to children and seniors through Columbia's DentCare program.

The New York State Department of Health (NYSDOH) determines where the mobile health clinic can provide services.

Date of Service	Site Name	Site Address	# of Children Seen	# of Referrals Given
5/2/2023	Washington Heights Child Care Center	610-14 West 175th St, NY, NY 10032	7	2
5/9/2023	Washington Heights Child Care Center	610-14 West 175th St, NY, NY 10032	8	4
5/16/2023	Washington Heights Child Care Center	610-14 West 175th St, NY, NY 10032	4	4
5/30/2023	Washington Heights Child Care Center	610-14 West 175th St, NY, NY 10032	9	3
6/15/2023	Washington Heights Child Care Center	610-14 West 175th St, NY, NY 10032	8	2
7/18/2023	Community Life Center Harlem River	258 West 153rd, NY, NY 10039	7	4
7/25/2023	Community Life Center Mt. Morris	15 Mt Morris Park W NY, NY 10027	10	5
8/1/2023	Community Life Center Mt. Morris	15 Mt Morris Park W NY, NY 10027	8	2
8/8/2023	Mama Tingo	519 West 189th St NY, NY 10040	8	4
8/15/2023	Mama Tingo	519 West 189th St NY, NY 10040	8	2
9/19/2023	EDCO 144th Street	249 W 144th Street NY, NY 10030	8	0
9/26/2023	EDCO 144th Street	249 W 144th Street NY, NY 10030	9	0
		Total	**94**	**32**

The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patients rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections. Columbia University follows the HIPAA Privacy Rule.

Additional Supporting Documentation

- Copies of public notifications and/or announcements of center services

Elected Officials, Community Members Turn Out to Help Launch Columbia's New Mobile Health Clinic

April 12, 2023

← News (/about-us/news)

The Columbia University College of Dental Medicine's mobile dentistry program is poised to double its capacity to deliver health screenings and low-cost dental care to residents of Northern Manhattan and the Bronx with the introduction of a new mobile health clinic, which has been generously funded by a $500,000 grant from the Mother Cabrini Health Foundation.

This van will boost CDM's capacity to meet clients in their communities and to conduct oral health screenings and primary care exams. Speaking at the new van's ribbon-cutting ceremony, Dr. Katrina Armstrong, chief executive officer of the Columbia University Irving Medical Center and dean of the faculties of health sciences and the Vagelos College of Physicians and Surgeons, said that the new van represents the university's ongoing commitment to serving vulnerable communities. "To care for a patient or a community, you can't separate oral health and heart health and metabolic health," she said. "You just think, as a mom, 'how can I take care of my kids or how do I help my parents get access to the healthcare that they need?'"

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Dr. Biana Roykh points out some of the new van's features for Assemblyman Al Taylor

The new mobile clinic is staffed by faculty and students at Columbia University's College of Dental Medicine and the Vagelos College of Physicians and Surgeons. Using an integrated model for both primary medicine and oral health that allows patients to receive comprehensive care, the new van features both a dental chair and a medical examination table. The clinic is equipped to offer a new level of interdisciplinary preventive care, including vaccinations, and is outfitted with dental instruments that capture biometric information to improve clinical care through the college's Center for Precision Dental Medicine.

This new model will enable CDM to create additional connections with community programs and centers, allowing the dental school to help more individuals in the community gain access to care and overall health education. It will also further enhance the service-learning experience for students, allowing them to meet patients where patients live, work, and go to school. "This mobile van symbolizes our collective commitment to the principle of advancing health equity," said Dennis Johnson, Cabrini Health Foundation's managing director for Strategy and evaluation, also speaking at the ribbon cutting.

The Honorable Adriano Espaillat, U.S. representative for the 13th congressional district, pledged continuing support for CUMC's outreach initiatives. "The medical school and dental school are important to this community," he said.

Soomin Park, a third-year student at CDM and co-president of the student-run Columbia Harlem Homeless Medical Partnership, which treats the under-documented, uninsured, and low-income populations of West Harlem, says she is excited that this new van will create the potential to treat more community members. "There are always more patients on the waiting list than we can treat," she said. Park said that the new van will help to reduce the number of people waiting to be seen.

Like the current mobile clinic, which was funded by grant from Delta Dental, the new van will travel to neighborhood schools, Head Start programs, daycare centers, foster care facilities, schools, nursing homes, rehabilitation centers, and health clinics in Harlem, Inwood, Washington Heights, and the South Bronx to provide onsite oral health care and preventive health services to children and seniors through Columbia's DentCare program. And, like the current clinic, the new, bright blue bus, emblazoned with photos of smiling children and senior citizens, reflects CDM's commitment to improve access to oral health and primary medicine in the communities it serves.

Dr. Amy Herbert, CDM's Director of Community Engagement and Partnerships notes, "CDM is currently partnered with various city schools, Head Start programs, and senior centers which facilitates access for communities who traditionally experience barriers to care. The integrated dental/medical van will address various needs of the community simultaneously."

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Topics

Dentistry (/news/topics/dentistry), Education (/news/topics/education), General Medicine (/news/topics/general-medicine), Public Health (/news/topics/public-health)

Columbia University College of Dental Medicine Dental Van

- *Exams*
- *Cleanings*
- *Fluoride application*
- *Oral health counseling*
- *Dental sealants*
- *Referrals*

www.dental.columbia.edu

Dentcarecdm@cumc.columbia.edu

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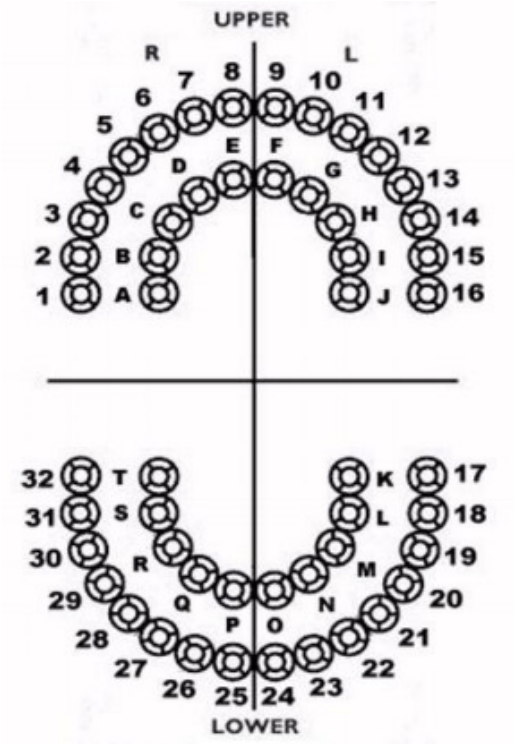
Dental Screening Report

Patient Name: Date: DOB:

Extra Oral Findings

Soft Tissue Findings



Dental Prosthesis:

Hard Tissue Findings

Tooth #	Problem	Recommendation

Plan/Recommendations/Notes for parent:

Provider:

Columbia DentCare
Screening Referral

Patient's Name:_____ **Date:**_____
Nombre del Paciente Fecha

Site name:

Site address:

Site phone:

Dental Concerns:

☐ **General Check-up** Chequeo de rutina ☐ **Needs a Dental Home** Necesita de hogar dental ☐**Emergency Visit** Visita Urgente

Hypertension/hipertensión: ☐ **Screening on:** **BP:**

Please Bring the Following Documentation to your Appointment:

1. This referral form./Este hoja de derivado.
2. Medicaid and/or Medicare insurance card. Tarjeta de Medicaid/Medicare.
3. Picture ID (NYS, any qualifying). Identificación del NYS (o cualquier otra calificativa)
4. List of your medications. Una lista de sus medicaciones.
5. Income verification: bank statement, hardship letter, W-2 (If you do not have medicaid)
   Verificación de ingresos: estado de cuenta, carta de dificultad, W-2 (si no tienes medicaid)

Columbia Referral Numbers/Números de Referidos a Columbia:

- ☐ General Dental Clinic/Clínica Dental General: (212) 305-6100
- ☐ Haven Pediatric Dental Clinic/Clínica Pediátrica Dental (212) 305-6754
- ☐ Columbia Primary Medical Care: (877) 426-5637

COLUMBIA UNIVERSITY
College of Dental Medicine

PLEASE USE INK ONLY TO COMPLETE

Dental Chart #:_____

COMMUNITY DENTCARE
PARENTAL CONSENT FOR DENTAL SERVICES

***** THIS CONSENT FORM MUST BE SIGNED ON THE 2ND PAGE TO AUTHORIZE DENTAL SERVICES *****

STUDENT INFORMATION

Student's Last Name: _____

Student's First Name: _____

Date of Birth: _____/_____/_____
Month Day Year

Sex: ❑ Male ❑ Female Grade _____

Ethnicity: ❑ Hispanic ❑ Black ❑ White ❑ American Indian ❑ Asian/Pacific Islander ❑ Other _____

Student Address: _____

_____

_____ _____ _____
City State Zip Code

Who is the student's regular dentist?

Name: _____

Telephone: _____

Address: _____

_____

_____

What school does the student attend? _____

PARENT/GUARDIAN INFORMATION

Mother

Last Name: _____ First Name: _____

D.O.B. _____

Father

Last Name: _____ First Name: _____

D.O.B. _____

Legal Guardian, If Applicable

Last Name: _____ First Name: _____

Relationship of legal guardian to student

❑ Grandparent ❑ Aunt or Uncle ❑ Other: _____

Contact Information for parent or guardian

Home Tel: _____ Work Tel: _____

Beeper/Cell: _____

Additional Emergency Contact

Name: _____

Relationship to Student: _____

Home Tel: _____ Work Tel: _____

Beeper/Cell: _____

INSURANCE INFORMATION

Does your child have Medicaid? ❑ No ❑ Yes:

Medicaid ID # _____

Does your child have a Medicaid Managed Care Plan?

If yes, which plan? _____

Managed Care Plan ID # _____

Does your child have a Commercial Insurance Plan?

If yes, which plan? _____

Commercial Insurance ID # _____

Does your child have other dental insurance?

❑ No ❑ Yes: Name: _____

Coverage Number: _____

Policy/ID #: _____

PARENTAL CONSENT FOR SCHOOL-BASED DENTAL SERVICES

I, parent or legal guardian of the above named minor child, hereby authorize and consent Columbia University College of Dental Medicine/ Columbia University Health Care, Inc. to perform dental examinations, take radiographs, diagnose, provide treatment and preventive services including but not limited to dental cleanings, sealants, fluoride treatments and to make referrals as needed for other services. I understand that the child will be treated in my absence. I understand that this consent will remain in force until I revoke it in writing. My signature also confirms that I have completed the medical history on the attached page and that this information is true and correct. If my child ever has a change in his/her health or his/her medicines I will inform the dentist as soon as possible.

SCHOOL BASED DENTAL HEALTH CENTER SERVICES

I consent for my child to receive dental care services provided by the State-licensed health professionals of Columbia University College of Dental medicine / Columbia University Health Care, Inc. (CUHC) as part of the school dental program approved by the New York State Department of Health. I understand that confidentiality between the student and the health provider will be ensured in specific service areas in accordance with the law, and that pupils will be encouraged to involve their parents or guardians in counseling and medical care decisions. Dental School-Based Health Center services may include, but are not limited to:

1. Dental examinations including: diagnosis, x-rays, treatment, and sealants where available.
2. Referrals for service not provided at the school-based health center.

PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS CONSENT
THIS FORM MUST BE SIGNED ON 2ND PAGE TO AUTHORIZE DENTAL SERVICES

COLUMBIA UNIVERSITY
College of Dental Medicine

PLEASE USE INK ONLY TO COMPLETE

Dental Chart #:_____

COMMUNITY DENTCARE
PARENTAL CONSENT FOR DENTAL SERVICES

***** THIS CONSENT FORM MUST BE SIGNED BELOW TO AUTHORIZE DENTAL SERVICES *****

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY

I, parent or legal guardian of the above child, hereby assign and set over to Columbia University College of Dental Medicine/Columbia University Health Care, Inc. sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers or others who are financially liable for my dental/medical care to cover the costs of the care and treatment rendered to my dependent. I understand that I will not be responsible for charges not covered by the insurance plan.

NEW YORK CITY DEPARTMENT OF EDUCATION'S
FACT SHEET FOR PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION
HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

My signature on this form authorizes release of medical information. This information may be protected from disclosure by federal privacy law and state law.

By signing this consent, I am authorizing medical information to be given to the Board of Education of the City of New York (a/k/a New York City Department of Education), either because it is required by law or by Chancellor's regulation, or because it is necessary to protect the health and safety of the student. Upon my request, the facility or person disclosing this medical information must provide me with a copy of this form. Parents are required by law to provide certain information to the school, like proof of immunization. Failure to provide this information may result in the student being excluded from school.

My questions about this form have been answered. I understand that I do not have to allow release of my child's medical information, and that I can change my mind at any time and revoke my authorization by writing to the School-Based Health Center. However, after a disclosure has been made, it cannot be revoked retroactively to cover information released prior to the revocation.

I authorize Columbia University College of Dental Medicine / Columbia University Health Care, Inc (CUHC) to release to the Board of Education of the City of New York (a/k/a New York City Department of Education), government agencies, insurance carriers or others who financially liable for the dental care and to make copies of all information needed to substantiate payment for such care of the student named on the reverse page.

PATIENT CONSENT TO ACCESS AND RELEASE TO ELECTRONIC PRESCRIBING MEDICATION HISTORY DATABASE

I authorize Columbia University College of Dental Medicine/Columbia University Health Care to access all electronic prescribing medication history databases and to release my prescription medication history contained in and sent to an electronic prescribing medication history databases (including but not limited to information related to HIV/AIDS, alcohol or drug use problems/treatment, family planning, genetic diseases, mental health conditions, and sexually transmitted diseases) used by Columbia University College of Dental Medicine/Columbia University Health Care. I understand this history may not be comprehensive and is limited to the medications which have been prescribed to me electronically. It is my responsibility to provide my dentist/ care provider with a complete list of medications I am currently taking. I understand that the purpose of this form is for Columbia University College of Dental Medicine/Columbia University Health Care to be able to access and exchange medication history information with authorized electronic prescribing services from other providers, pharmacies and/or third party pharmacy benefit programs/payors.

By signing this form, I am authorizing the access, use or disclosure of protected health information as indicated above. I may revoke authorization in this form at any time before the information I have requested is released or is acted upon in reliance of this authorization by providing written notice of revocation as specified in the Notice of Privacy Practices. If the receiving party is not subject to medical information privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law. Columbia University College of Dental Medicine/Columbia University Health Care, Inc. shall not be held liable for any consequences resulting from re-disclosure. I will be provided with a copy of this form. I may request a copy of my health information.

This Consent and Authorization does not expire unless I revoke in writing or upon termination of my treatment relationship with Columbia University College of Dental Medicine/Columbia University Health Care, Inc.

By electronically signing this form, I hereby state that I have read and understood it, and that I have been given the opportunity to ask questions and that all my questions have been answered in a satisfactory manner.

HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION AND CONSENT TO ACCESS AND RELEASE TO ELECTRONIC PRESCRIBING MEDICATION HISTORY DATABASE

I hereby state that I have read and understood this consent form, and that I have been given the opportunity to ask questions, I may have, and all my questions have been answered in a satisfactory manner.

X

_____

Signature of Parent/Legal Guardian ***(or student if 18 years or older or otherwise permitted by law)***

Date_____

PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS CONSENT
THIS FORM MUST BE SIGNED ON 2ND PAGE TO AUTHORIZE DENTAL SERVICES

COLUMBIA | COLLEGE OF DENTAL MEDICINE

Dental Consent for Treatment and Release of Information

Patient Name: **Date:**

CONSENT FOR GENERAL DENTAL TREATMENT

I consent to diagnostic procedures and treatment by Columbia University College of Dental Medicine/Columbia University Health Care, Inc. deemed necessary for my care by the attending faculty member. I further understand that any and or all clinical care (operations, procedures, techniques and clinical imaging) will be provided by student(s) or resident(s). In order to maintain the highest quality of care and to improve the skills of students and residents, I also consent to having clinical encounters observed and possibly recorded by video cameras and may be reviewed by attending faculty member with the student or resident provider.

I understand that prior to any clinical care (operations, procedures, techniques and clinical imaging), I will be advised by the student, resident or faculty member responsible for my care, and that I may ask questions concerning my treatment. I also understand that post-treatment complications including bleeding, pain, swelling, loss of teeth, and loss of implants may be a normal consequence of the treatment rendered. I further understand that I may revoke this consent before such treatment is provided. I understand this consent will remain in force unless I revoke it in writing.

I further understand that the fee(s) provided in the treatment plan are estimated and relate only to the essential procedures. If any additional treatment(s) is not included in the fees estimated in the proposed treatment plan at this time, I will be financially responsible for any changes as part of the additional treatment.

I agree to abide by all the rules and regulations of Columbia University College of Dental Medicine/Columbia University Health Care, Inc.

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY

I assign and set over to Columbia University College of Dental Medicine/Columbia University Health Care, Inc. sufficient monies and/or benefits to which I may be entitled from a government agency, insurance carrier or others who are financially liable for my dental or medical care to cover the costs of the care and treatment rendered to myself or my dependent. I understand that I am responsible for charges not covered by my insurance plan.

I am aware and acknowledge that no guarantees, warranties or assurance of success have been made to me by Columbia University College of Dental Medicine / Columbia University Health Care, Inc. regarding treatment and the treatment results for any dental treatment.

APPOINTMENT POLICY and GUIDE to PATIENT SERVICES ACKNOWLEDGEMENT RECEIPT

We take great pride in the quality of care that we deliver. In effort to maintain this high-level of care, we have instituted appointment guidelines regarding cancellations/no-show/lateness. Compliance with this policy will allow patients to receive treatment in a timely and efficient manner, promoting optimal care and oral health.

1. Once appointments are scheduled, patients are expected to attend each and every session at the appointed time.

COLUMBIA | COLLEGE OF DENTAL MEDICINE

2. If you are going to be late for scheduled appointment, please call to let us know so that we may notify your doctor.

3. All cancellations must be communicated to the department 48 hours in advance or 72 hours in advance of a surgical and/or sedation procedure.

4. If you cancel or fail to show for three consecutive visits, you may be discharged from being provided care at the college.

5. If you fail to contact us in 2 weeks after being sent a "warning letter" you will be discharged from the College of Dental Medicine.

6. The College reserves the right not to reschedule patients who have been discharged for failing to show for prior scheduled appointments.

We appreciate your understanding and cooperation with this policy.

I have read, understand, and agree to abide by the aforementioned policy.

I acknowledge that I was provided with a copy of the College of Dental Medicine Guide to Patient Services.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize Columbia University College of Dental Medicine/Columbia University Health Care, Inc. to release to government agencies, insurance carriers, or others who are financially liable for dental and medical care, all information needed to substantiate payment for such care, and allow others who are representatives thereof to examine and make copies of all records relating to my care and treatment.

This Consent and Authorization does not expire unless I revoke in writing or upon termination of my treatment relationship with Columbia University College of Dental Medicine/Columbia University Health Care, Inc.

By electronically signing this form, I hereby state that I have read and understood it, and that I have been given the opportunity to ask questions I might have, and that all my questions have been answered in a satisfactory manner.

Patient Name:

Relationship to patient:

○Mother ○Father ○Grandparent ○Aunt/Uncle ○Sibling ○Other

Columbia University Health Care, Inc.
Community DentCare Network

Dental Chart #: _____

PEDIATRIC MEDICAL HISTORY FORM
(RESUMEN MEDICO PEDIATRICO)

STUDENT/PATIENT INFORMATION (Informacion del Estudiante/Paciente)

Last Name: _____ First Name: _____
(Apellido) (Primer Nombre)

Date of Birth: _____/_____/_____ Age _____
(Fecha de Nacimiento) Month Day Year (Edad)

Ethnic: Hispanic ☐ Black ☐ White ☐ Other ☐ Sex: Male ☐ Female ☐
(Raza) (Hispano) (Negro) (Blanco) (Otra) (Sexo) (Masculino) (Femenino)

Please circle the appropriate answer - Por favor marque con un circulo la respuesta correcta

Health Problems? YES (SI) NO
Problemas de salud?

Presently under a doctor's care? YES (SI) NO
Esta bajo tratamiento medico?

Are the patient's vaccinations up-to-date? YES (SI) NO
Estan las vacunaciones al dia?

Does he/she have or has had abnormal bleeding associated with previous surgery, dental extractions or accident? YES (SI) NO
Tiene o ha tenido sangramiento anormal o excesivo asociado con cirugia previa, extracciones dentales o accidentes ?

Does he/she bruise easily? YES (SI) NO
Se le forman hematomas facilmente?

Has he/she ever required a blood transfusion? YES (SI) NO
Ha requerido de tranfusiones sanguineas?

Does he/she have a disability that requires special treatment in a dental office? YES (SI) NO
Tiene algun impedimento fisico o mental que requiera tratamiento especial en el consultorio dental?

Has he/she ever had any trouble associated with any previous dental treatment? YES (SI) NO
Ha tenido algun problema asociado con algun tratamineto dental?

Is he /she taking any of the following medicine?
Toma actualmente alguna de las siguiente medicinas?

Antibiotic or Sulfa (*Antibioticos o Sulfonamidas*) YES (SI) NO
Anticoagulants/Blood Thinners (Anticoagulantes) YES (SI) NO
Medicine for High Blood Pressure YES (SI) NO
(Medicinas para la Presion Arterial Elevada)
Cortisone or Steroids (Cortisona o Esteroides) YES (SI) NO
Tranquilizers (Tranquilizantes) YES (SI) NO
Aspirin (Aspirina) YES (SI) NO
Dilantin or other Anticonvulsant YES (SI) NO
(Dilantin o algun otro Anticonvulsante)
Insulin, Tolbutamide, Orinase or similar drug YES (SI) NO
(Insulina, Tolbutamide, Orinase o alguna droga similar)
Any Other? (Alguna Otra?) _____

Has he/she ever had an adverse reaction to any of the following?
Ha tenido alguna vez una reaccion desfavorable a lo siguiente?

Local Anesthetics (Anestesicos Locales) YES (SI) NO
Penicillin or Antibiotics (Penicilina o Antibioticos) YES (SI) NO
Sulfa Drugs (Sulfonamidas) YES (SI) NO
Barbiturates, sedatives or sleeping pills YES (SI) NO
(Barbituricos, sedativos o pastillas para dormir)
Aspirin (Aspirina) YES (SI) NO
Any other Drugs? _____ YES (SI) NO
(Algun otro medicamento?)

Has he/she been in a situation which could have exposed him/her to X-rays or other ionizing radiation? YES (SI) NO
Ha sido expuesto a radiaciones?

LAST DENTAL VISIT (DATE) _____
ULTIMA VISITA DENTAL (FECHA)

Has he/she ever had orthodontic treatment (worn braces)? YES (SI) NO
Ha recibido tratamiento ortodontico (usado braces)?

Has he/she ever been treated for any gum diseases (Gingivitis, Periodontitis, Trechmouth, Piorrhea) ? YES (SI) NO
Ha sido atendido alguna vez de enfermedades de las encias?
(Gingivitis, Periodontitis, Trechmouth, Pyorrhea) ?

Does his/her gums bleed when brushing teeth? YES (SI) NO
Sangran sus encias cuando se cepilla los dientes?

Does he/she grind or clench teeth? YES (SI) NO
Rechinan sus dientes?

Has he/she often had toothaches? YES (SI) NO
Tiene dolor de dientes o muelas frecuente?

Does he/she have frequent sores in his/her mouth? YES (SI) NO
Tiene o ha tenido ulceritas frecuentes en su boca?

Has he/she had any injuries to his/her mouth or jaws? YES (SI) NO
Ha tenido o sufrido golpes en su boca o quijada?
If yes, explain: (Si es asi, explique) _____

Does he/she have any swelling of his/her mouth or jaws? YES (SI) NO
Se le incha la boca o quijada?

Please use INK ONLY and complete information on the reverse side of this form. →
Favor de usar TINTA SOLAMENTE y de completar la informacion al dorso de esta pagina. →

Columbia University Health Care, Inc.
Community DentCare Network

Dental Chart #: _____

Does your child have or ever had, any of the following diseases/medical conditions? please circle YES or NO

Tiene a ha tenido su niño(a) algunas de las siguientes enfermedades/sintomas medico? por favor marque SI o NO

Allergies (Alergias)	YES (SI) NO	Fainitng Spells (Desmayos)	YES (SI) NO
Foods (Alimentos)	YES (SI) NO	Hearing Disability (Trastornos Auditivos)	YES (SI) NO
Other (Otras Alergias) _____		Hepatitis, Jaundice, Liver Disease	YES (SI) NO
Anemia	YES (SI) NO	(Hepatitis o Enfermedades del Higado)	
Asthma (Asma)	YES (SI) NO	HIV (VIH)	YES (SI) NO
Arthritis (Artritis)	YES (SI) NO	Hives or Skin Rash (Erupciones Cutaneas/Urticarias)	YES (SI) NO
Cardiovascular Disease (Enfermedades Cardiovasculares)	YES (SI) NO	Kidney Disease (Enfermedades Renales)	YES (SI) NO
Heart problems (Problemas del corazon)	YES (SI) NO	Mentally Handicap (Impedimento Mental)	YES (SI) NO
High Blood Pressure (Presion Alta)	YES (SI) NO	Persistent Cough or Cough Up Blood	YES (SI) NO
Low Blood Pressure (Presion Baja)	YES (SI) NO	(Tos persistente o Sangrado cuando tose)	
Other - Explain (Otro - Explique) _____		Psychiatric Treatment (Tratamiento Psiquiatrico)	YES (SI) NO
Cerebral Palsy (Paralisis Cerebral)	YES (SI) NO	Rheumatoid Fever (Fiebre Reumatica)	YES (SI) NO
Cleft Lip/Palate (labio leporino/Paladar Hendido)	YES (SI) NO	Sickle Cell Disease (Anemia de Celulas Falciformes)	YES (SI) NO
Congenital Heart Disease	YES (SI) NO	Stomach Ulcers (Ulceras Gastricas)	YES (SI) NO
(Enfermedades Congenitas del Corazon)		Thyroid Disease (Enfermedades de la Glandula Tiroides)	YES (SI) NO
Diabetes	YES (SI) NO	Tuberculosis (TB)	YES (SI) NO
Emphysema (Enfisema)	YES (SI) NO	Veneral Disease (Enfermedades Venereas)	YES (SI) NO
Epilepsy/Seizures (Epilepsia/Convulsiones)	YES (SI) NO	Other -Explain (Otra - Explique) : _____	

If you answered "YES" to any of the above questions, please explain:
(Si ha contestado "SI" a algunas de las preguntas anteriormente, por favor explique):

_____
_____
_____

To the best of my knowledge, all of the preceding answers are true and correct. If my child ever has a change in his/her health or his/hers medicines, I will inform the doctor/dentist as soon as possible.

Certifico que todas las preguntas anteriormente fueron contestadas veraz y correctamente. Si mi hijo(a), tiene un cambio de salud, o comienza a tomar algun medicamento nuevo, debere informarle al dentista/doctor lo antes posible.

X _____

Signature of Parent/Guardian ***Date***
Firma del Padre, Madre o Tutor Legal ***Fecha***

For Office Use Only

Medical History Reviewed By:

Comments: _____
_____
_____

_____ _____ _____
Reviewer's Name (print) *Signature of Reviewer* *Date*

Please complete information on the reverse side of this form. Favor de completar la informacion al dorso de esta pagina.

REVISED 01/22/2018

COLUMBIA | COLLEGE OF DENTAL MEDICINE

Consentimiento para el tratamiento dental y la divulgación de información

Dental Consent for Treatment and Release of Information

Nombre del paciente: **Fecha:**
MRN:

CONSENTIMIENTO PARA EL TRATAMIENTO DENTAL GENERAL

Doy mi consentimiento para que Columbia University College of Dental Medicine/Columbia University Health Care, Inc. realice los procedimientos de diagnóstico y tratamiento que el miembro de la facultad que me atiende considere necesarios para mi cuidado. Además, entiendo que, cualquier y/o todos los cuidados clínicos (operaciones, procedimientos, técnicas e imágenes clínicas) serán proporcionados por estudiantes o residentes. A fin de mantener la más alta calidad del cuidado y mejorar las destrezas de los estudiantes y residentes, también acepto que los encuentros clínicos sean observados y posiblemente grabados por cámaras de video y que puedan ser revisados por el miembro de la facultad que me atiende con el proveedor residente o estudiante.

Entiendo que antes de cualquier atención clínica (operaciones, procedimientos, técnicas e imágenes clínicas), seré asesorado por un estudiante, residente o miembro de la facultad responsable de mi cuidado y que puedo hacer preguntas relacionadas con mi tratamiento. También entiendo que las complicaciones posteriores al tratamiento, incluyendo sangrado, dolor, hinchazón, pérdida de dientes y pérdida de implantes, pueden ser una consecuencia normal del tratamiento realizado. Entiendo además que puedo revocar este consentimiento antes de que se proporcione dicho tratamiento. Comprendo que este consentimiento permanecerá en vigor a menos que lo revoque por escrito.

Entiendo además que los costos proporcionados son estimados y se refieren únicamente a los procedimientos esenciales. Si algún tratamiento adicional no está incluido en los costos estimados en el plan de tratamiento propuesto en este momento, yo seré responsable financieramente de cualquier cargo que sea parte del tratamiento adicional.

Me comprometo a cumplir con todas las normas y reglamentos de Columbia University College of Dental Medicine/Columbia University Health Care, Inc.

ASIGNACIÓN DE BENEFICIOS Y RESPONSABILIDAD FINANCIERA

Asigno y traspaso a Columbia University College of Dental Medicine/Columbia University Health Care, Inc. los fondos suficientes y/o beneficios a los que pueda tener derecho de parte de una agencia gubernamental, compañía de seguros u otros que sean responsables financieramente de mi atención dental o médica para cubrir los costos de la atención y el tratamiento que se me presten a mí o a mi dependiente. Entiendo que soy responsable de los cargos no cubiertos por mi plan de seguro.

Soy consciente y reconozco que Columbia University College of Dental Medicine / Columbia University Health Care, Inc. no me ha garantizado, prometido ni asegurado el éxito del tratamiento ni de los resultados de ningún tratamiento dental.

POLÍTICA DE CITAS y CONFIRMACIÓN del RECIBO de la GUÍA DE SERVICIOS AL PACIENTE

Nos enorgullece la calidad de la atención que ofrecemos. En un esfuerzo por mantener este alto nivel de atención, hemos instituido directrices para las citas en relación con las cancelaciones, el no presentarse y la impuntualidad. El cumplimiento de estas políticas permitirá que los pacientes reciban tratamiento de manera oportuna y eficiente, promoviendo el cuidado óptimo y la salud oral.

COLUMBIA | COLLEGE OF DENTAL MEDICINE

1. Una vez que se programan las citas, se espera que los pacientes asistan a todas y cada una de ellas a la hora indicada.

2. Si va a llegar tarde a la cita programada, por favor, llámenos para avisarnos y así nosotros podremos avisarle a su médico.

3. Se deben comunicar todas las cancelaciones al departamento con 48 horas de anticipación o 72 horas antes si se trata de un procedimiento quirúrgico y/o de sedación.

4. Si cancela o no se presenta a tres visitas consecutivas, se le podrá dejar de proporcionar atención en el College of Dental Medicine.

5. Si no se pone en contacto con nosotros dentro de las dos semanas después de haber recibido una "carta de advertencia", se le dará de baja del College of Dental Medicine.

6. El College of Dental Medicine se reserva el derecho de no volver a citar a los pacientes que han sido dados de baja por no presentarse a las citas programadas previamente.

Apreciamos su comprensión y cooperación con esta política.

He leído, entendido y estoy de acuerdo en cumplir con la política mencionada.

Confirmo que me han proporcionado una copia de la Guía de Servicios al Paciente de College of Dental Medicine.

AUTORIZACIÓN PARA LA DIVULGACIÓN DE INFORMACIÓN MÉDICA

Autorizo a Columbia University College of Dental Medicine/Columbia University Health Care, Inc. para que comparta con los organismos gubernamentales, compañías de seguros u otras personas que sean responsables financieramente de la atención dental y médica, toda la información necesaria para fundamentar el pago de dicha atención, y para que permita que otras personas que sean representantes de estas entidades examinen y hagan copias de todos los registros relacionados con mi atención y tratamiento.

Este consentimiento y autorización no caduca a menos que yo lo revoque por escrito o al terminar mi relación de tratamiento con Columbia University College of Dental Medicine/Columbia University Health Care, Inc.

Al firmar electrónicamente este formulario, declaro que lo he leído y comprendido, y que he tenido la oportunidad de hacer las preguntas que pudiera tener, y que todas mis preguntas han sido contestadas de manera satisfactoria.

Nombre del paciente:

Relación con el paciente:

Madre Padre Abuelo(a) Tío(a) Hermano(a) Otro Tutor legal

COLUMBIA UNIVERSITY
College of Dental Medicine

POR FAVOR USE TINTA SOLAMENTE Historia Dental #_____

COMMUNITY DENTCARE

CONSENTIMIENTO DE LOS PADRES PARA SERVICIOS DENTALES

**** ESTE CONSENTIMIENTO REQUIERE SU AUTORIZACION EL LA 2-NDA PAGINA ****

INFORMACION DEL ESTUDIANTE

Apellido: _____

Nombre: _____

Fecha de nacimiento: _____/_____/_____
Mes Dia Año

Sexo: ❑ Masculino ❑ Femenino Grado _____

Etnicidad: ❑ Hispano ❑ Negro ❑ Blanco ❑ Indio Americano ❑ Asiático/Isla del Pacífico ❑ Otro_____

Dirección: _____

_____

_____ _____ _____
Ciudad Estado Código de área

Quién es el dentista regular del estudiante?

Nombre:_____

Teléfono: _____

Dirección: _____

_____

_____

A qué escuela asiste el estudiante?_____

INFORMACION DE LOS PADRES/TUTOR

Madre

Apellido: _____ Nombre: _____

Fecha de Nacimiento _____/_____/_____

Padre

Apellido: _____ Nombre: _____

Fecha de Nacimiento _____/_____/_____

Tutor legal, si aplica:

Apellido _____ Nombre _____

Relación del tutor legal con el estudiante

❑ Abuelo(a) ❑ Tío(a) ❑ Otro _____

Informacion para contactar a los padres o tutor legal

Casa # Tel: _____Trabajo #Tel _____

Celular: _____

Contacto de Emergencia Adicional

Nombre_____

Relación con el Estudiante: _____

Casa Tel: _____ Trabajo Tel: _____

Celular: _____

INFORMACION DEL SEGURO

¿Tiene su niño(a) Medicaid? ❑ No ❑ Sí

Medicaid ID # _____

¿Tiene su niño(a) un *Plan de Medicaid Managed Care*? ❑No ❑Sí

Nombre de plan: _____

Numero de plan: _____

¿Tiene su niño(a) un seguro *commercial* ? ❑ No ❑ Sí

Nombre de plan: _____

Numero de plan: _____

¿Tiene su niño(a) otro seguro dental ?

❑ No ❑ Sí Nombre de seguro_____

Número: _____

Poliza ID #: _____

CONSENTIMIENTO DE PADRES O TUTORES PARA RECIBIR SERVICIOS DENTALES EN LA ESCUELA

Yo, padre o tutor legal del menor mencionado anteriormente, otorgo mi consentimiento para el tratamiento y los procedimientos diagnósticos (incluyendo las técnicas) por parte de la Facultad de Medicina Dental de la Universidad de Columbia/Columbia University Health Care, Inc., para hacer exámenes dentales, tomar radiografias, diagnosticar y proveer servicios preventivos incluyendo pero no limitados a limpiezas dentales, fluor sellantes, tratamiento de caries (empastes/rellenos, y referidos para otros servicios según sea necesario.

Estoy de acuerdo en cumplir con todas las reglas y regulaciones de la Facultad de Medicina Dental de la Universidad de Columbia/Columbia University Health Care, Inc. Entiendo que antes de cualquier tratamiento o procedimiento diagnóstico (incluyendo las técnicas) o la obtención de fotografías clínicas, seré notificado por la facultad responsable de mi cuidado y puedo hacer preguntas relacionadas con mi tratamiento. También entiendo que las complicaciones pos-tratamiento, pueden ser una consecuencia normal del tratamiento proporcionado. Además, entiendo que puedo revocar (cancelar) este consentimiento antes de que ese tratamiento sea realizado. Comprendo que este consentimiento seguirá vigente a no ser que yo lo cancele por escrito.

Yo entiendo que el/la niño(a) será tratado en mi ausencia. Mi firma además confirma que yo he completado el cuestionario sobre la historia médica en la página adjunta y que esta información es verdadera y correcta. Si mi niño(a) alguna vez tiene cambios en su salud o sus medicina, yo le informaré al dentista tan pronto como sea posible.

SERVICIOS DE LOS CENTROS DE SALUD DENTAL ESCOLARES

Yo doy consentimiento para que mi niño(a) reciba servicios dentales proveidos por profesionales de la salud de Columbia University College of Dental Medicine / Columbia University Health Care, Inc (CUHC) con licencia del estado, como parte del programa dental escolar aprovado por el Departamento de Salud del Estado de New York. Yo entiendo que la confidencialidad entre el estudiante y el proveedor de salud será asegurada en areas específicas del servicio de acuerdo con la ley y que los estudiantes serán aconsejados para que envuelvan a los padres o tutores legales en la toma de deciciones de salud.

Servicios en los centros dentales escolares pueden incluir, pero no estan limitados a:

1. Examinaciones dentales incluyendo: dianóstIco, tratamiento (empastes/rellenos, extracciones), y sellantes para prevención de acuerdo a la disponibilidad.
2. Referidos para los servicios que no se proveen en el centro de salud dental escolar.

POR FAVOR LEA LOS DOS LADOS DE ESTE FORMULARIO

****ESTE CONSENTIMIENTO REQUIERE SU AUTORIZACION EL LA 2NDA PAGINA**

COLUMBIA UNIVERSITY
College of Dental Medicine

POR FAVOR USE TINTA SOLAMENTE Historia Dental #_____

CONSENTIMIENTO DE LOS PADRES PARA SERVICIOS DENTALES

ASIGNACION DE BENEFICIOS *Y RESPONSIBIDA FINANCIAL*

Yo, padre o tutor legal del menor mencionado anteriormente, por medio de la presente asigno y cedo al mencionado Columbia University College of Dental Medicine/Columbia University health Care, Inc. los fondos suficientes y/o beneficios a los cuales yo podría tener derecho de una agencia del gobierno, compañías de seguros u otras personas que son economicamente responsables del cuidado dental/médico para cubrir los costos de la atención y el tratamiento prestado a mis dependientes en dicha práctica, Entiendo que no habrá ningún costo para mí o mi dependiente.

DEPARTMENTO DE EDUCACION DE LA CIUDAD DE NEW YORK
DATOS SOBRE EL CONSENTIMIENTO DE LOS PADRES PARA LA DIVULGACIÓN DE INFORMACIÓN MÉDICA
CONSENTIMIENTO DE LOS PADRES PARA LA DIVULGACIÓN DE INFORMACIÓN MÉDICA DE ACUERDO A HIPAA

Mi firma en el reverso de este formulario autoriza la divulgación de información médica. Esta información puede ser protegida de la divulgación por la ley de privacidad federal y la ley estatal.

Al firmar este consentimiento, autorizo para dar información médica a la Junta de Educación de la Ciudad de Nueva York (también conocida como el Departamento de Educación de la Ciudad de Nueva York) , ya sea porque se requiere por ley o por reglamento del canciller, o porque sea necesario para proteger la salud y seguridad del estudiante . A petición mía, la institución o persona que divulgará esta información médica debe proporcionarme una copia de este formulario. Los padres están obligados por ley a proporcionar cierta información a la escuela, como pruebas de inmunización. No proporcionar esta información puede resultar en que el estudiante sea excluido de la escuela.

Mis preguntas sobre este formulario han sido respondidas. Entiendo que no tengo que autorizar la divulgación de la información médica de mi hijo(a), y que puedo cambiar de opinión en cualquier momento y revocar mi autorización por escrito al Centro de Salud Escolar. Sin embargo, después de que la información se haya revelado, no puede ser revocada con efecto retroactivo para cubrir la información divulgada antes de la revocación.

Autorizo a la Universidad de Columbia Colegio de Medicina Dental / Columbia University Health Care, Inc (CUHC) para divulgar información médica específica del estudiante mencionado en el reverso de la página a la Junta de Educación de la Ciudad de Nueva York (también conocida como Departamento de Educación de la ciudad de New York).

CONSENTIMIENTO DEL PACIENTE PARA ACCEDER Y REVELAR LA INFORMACIÓN A LA BASE DE DATOS DEL HISTORIAL DE MEDICAMENTOS PRESCRITOS ELECTRÓNICAMENTE

Yo autorizo a la Facultad de Medicina Dental de la Universidad de Columbia/Columbia University Health Care, Inc. a tener acceso a todas las bases de datos del historial de medicamentos prescritos electrónicamente y revelar mi historial de medicamentos prescritos contenido en ellas y enviado a las bases de datos del historial de medicamentos prescritos electrónicamente (incluyendo, entre otros, la información relacionada con el VIH/SIDA, tratamiento/problemas con el consumo de alcohol o drogas, planificación familiar, enfermedades genéticas, afecciones de salud mental y enfermedades de transmisión sexual) usadas por la Facultad de Medicina Dental de la Universidad de Columbia/Columbia University Health Care, Inc. Entiendo que este historial no puede ser completo y está limitado a los medicamentos que me han prescrito electrónicamente. Es mi responsabilidad proporcionar a mi dentista/proveedor de atención una lista completa de los medicamentos que estoy tomando actualmente. Comprendo que el fin de este formulario es para que la Facultad de Medicina Dental de la Universidad de Columbia/Columbia University Health Care, Inc. pueda acceder e intercambiar la información del historial de medicamentos con los servicios de prescripción electrónica autorizados de otros proveedores, farmacias y/o tercera parte pagadores/programas de beneficios de farmacia.

Al firmar este formulario, autorizo el acceso, uso o la revelación de la información protegida de salud como se indicó anteriormente. Puedo revocar (cancelar) la autorización en este formulario en cualquier momento antes de que la información que he solicitado sea revelada o se haya actuado según lo dispuesto en esta autorización, mediante una notificación por escrito de la revocación como especifica el Aviso de las Prácticas de la Privacidad. Si la parte receptora no está sujeta a las leyes de la privacidad de la información médica, la información se puede volver a revelar por parte del receptor y posiblemente ya no sea protegida por la ley federal o estatal. La Facultad de Medicina Dental de la Universidad de Columbia/Columbia University Health Care, Inc. no será responsable de ninguna consecuencia por volver a revelarla. Me entregarán una copia de este formulario. Puedo solicitar una copia de mi información de salud.

Este Consentimiento y Autorización no tiene fecha de vencimiento, a no ser que yo lo revoque por escrito o al finalizar mi relación de tratamiento con la Facultad de Medicina Dental de la Universidad de Columbia/Columbia University Health Care, Inc.

Al firmar electrónicamente, yo declaro por la presente que, he leído y entendido el documento, que me han dado la oportunidad de hacer las preguntas que he tenido y que respondieron satisfactoriamente a todas mis preguntas.

CONSENTIMIENTO DE LOS PADRES PARA LA DIVULGACION DE INFORMACION DE SALUD-HIPAA *Y LA AUTORIZACION PARA USAR Y REVELAR LA INFORMACIÓN MÉDICA Y DENTAL*

Por medio de la presente declaro que he leído y entendido este formulario de consentimiento, que se me ha dado la oportunidad de hacer preguntas, y todas mis preguntas han sido contestadas de manera satisfactoria.

X _____ _____

Firma del padre/ tutor legal *(o el estudiante si tiene 18 años o más, o permitido por la ley)* Fecha

POR FAVOR LEA LOS DOS LADOS DE ESTE FORMULARIO
****ESTE CONSENTIMIENTO REQUIERE SU AUTORIZACION EL LA 2NDA PAGINA**

Columbia University Health Care, Inc.
Community DentCare Network

Dental Chart #: _____

PEDIATRIC MEDICAL HISTORY FORM
(RESUMEN MEDICO PEDIATRICO)

STUDENT/PATIENT INFORMATION (Informacion del Estudiante/Paciente)

Last Name: _____ First Name: _____
(Apellido) (Primer Nombre)

Date of Birth: _____/_____/_____ Age _____
(Fecha de Nacimiento) Month Day Year (Edad)

Ethnic: Hispanic ☐ Black ☐ White ☐ Other ☐ Sex: Male ☐ Female ☐
(Raza) (Hispano) (Negro) (Blanco) (Otra) (Sexo) (Masculino) (Femenino)

Please circle the appropriate answer - Por favor marque con un circulo la respuesta correcta

Health Problems? YES (SI) NO
Problemas de salud?

Presently under a doctor's care? YES (SI) NO
Esta bajo tratamiento medico?

Are the patient's vaccinations up-to-date? YES (SI) NO
Estan las vacunaciones al dia?

Does he/she have or has had abnormal bleeding associated with previous surgery, dental extractions or accident? YES (SI) NO
Tiene o ha tenido sangramiento anormal o excesivo asociado con cirugia previa, extracciones dentales o accidentes ?

Does he/she bruise easily? YES (SI) NO
Se le forman hematomas facilmente?

Has he/she ever required a blood transfusion? YES (SI) NO
Ha requerido de tranfusiones sanguineas?

Does he/she have a disability that requires special treatment in a dental office? YES (SI) NO
Tiene algun impedimento fisico o mental que requiera tratamiento especial en el consultorio dental?

Has he/she ever had any trouble associated with any previous dental treatment? YES (SI) NO
Ha tenido algun problema asociado con algun tratamineto dental?

Is he /she taking any of the following medicine?
Toma actualmente alguna de las siguiente medicinas?

Antibiotic or Sulfa (*Antibioticos o Sulfonamidas*) YES (SI) NO
Anticoagulants/Blood Thinners (Anticoagulantes) YES (SI) NO
Medicine for High Blood Pressure YES (SI) NO
(Medicinas para la Presion Arterial Elevada)
Cortisone or Steroids (Cortisona o Esteroides) YES (SI) NO
Tranquilizers (Tranquilizantes) YES (SI) NO
Aspirin (Aspirina) YES (SI) NO
Dilantin or other Anticonvulsant YES (SI) NO
(Dilantin o algun otro Anticonvulsante)
Insulin, Tolbutamide, Orinase or similar drug YES (SI) NO
(Insulina, Tolbutamide, Orinase o alguna droga similar)
Any Other? (Alguna Otra?) _____

Has he/she ever had an adverse reaction to any of the following?
Ha tenido alguna vez una reaccion desfavorable a lo siguiente?

Local Anesthetics (Anestesicos Locales) YES (SI) NO
Penicillin or Antibiotics (Penicilina o Antibioticos) YES (SI) NO
Sulfa Drugs (Sulfonamidas) YES (SI) NO
Barbiturates, sedatives or sleeping pills YES (SI) NO
(Barbituricos, sedativos o pastillas para dormir)
Aspirin (Aspirina) YES (SI) NO
Any other Drugs? _____ YES (SI) NO
(Algun otro medicamento?)

Has he/she been in a situation which could have exposed him/her to X-rays or other ionizing radiation? YES (SI) NO
Ha sido expuesto a radiaciones?

LAST DENTAL VISIT (DATE) _____
ULTIMA VISITA DENTAL (FECHA)

Has he/she ever had orthodontic treatment (worn braces)? YES (SI) NO
Ha recibido tratamiento ortodontico (usado braces)?

Has he/she ever been treated for any gum diseases (Gingivitis, Periodontitis, Trechmouth, Piorrhea) ? YES (SI) NO
Ha sido atendido alguna vez de enfermedades de las encias?
(Gingivitis, Periodontitis, Trechmouth, Pyorrhea) ?

Does his/her gums bleed when brushing teeth? YES (SI) NO
Sangran sus encias cuando se cepilla los dientes?

Does he/she grind or clench teeth? YES (SI) NO
Rechinan sus dientes?

Has he/she often had toothaches? YES (SI) NO
Tiene dolor de dientes o muelas frecuente?

Does he/she have frequent sores in his/her mouth? YES (SI) NO
Tiene o ha tenido ulceritas frecuentes en su boca?

Has he/she had any injuries to his/her mouth or jaws? YES (SI) NO
Ha tenido o sufrido golpes en su boca o quijada?
If yes, explain: (Si es asi, explique) _____

Does he/she have any swelling of his/her mouth or jaws? YES (SI) NO
Se le incha la boca o quijada?

Please use INK ONLY and complete information on the reverse side of this form. →
Favor de usar TINTA SOLAMENTE y de completar la informacion al dorso de esta pagina. →

Columbia University Health Care, Inc.
Community DentCare Network

Dental Chart #: _____

Does your child have or ever had, any of the following diseases/medical conditions? please circle YES or NO

Tiene a ha tenido su niño(a) algunas de las siguientes enfermedades/sintomas medico? por favor marque SI o NO

Allergies (Alergias)	YES (SI) NO	Fainitng Spells (Desmayos)	YES (SI) NO
Foods (Alimentos)	YES (SI) NO	Hearing Disability (Trastornos Auditivos)	YES (SI) NO
Other (Otras Alergias) _____		Hepatitis, Jaundice, Liver Disease	YES (SI) NO
Anemia	YES (SI) NO	(Hepatitis o Enfermedades del Higado)	
Asthma (Asma)	YES (SI) NO	HIV (VIH)	YES (SI) NO
Arthritis (Artritis)	YES (SI) NO	Hives or Skin Rash (Erupciones Cutaneas/Urticarias)	YES (SI) NO
Cardiovascular Disease (Enfermedades Cardiovasculares)	YES (SI) NO	Kidney Disease (Enfermedades Renales)	YES (SI) NO
Heart problems (Problemas del corazon)	YES (SI) NO	Mentally Handicap (Impedimento Mental)	YES (SI) NO
High Blood Pressure (Presion Alta)	YES (SI) NO	Persistent Cough or Cough Up Blood	YES (SI) NO
Low Blood Pressure (Presion Baja)	YES (SI) NO	(Tos persistente o Sangrado cuando tose)	
Other - Explain (Otro - Explique) _____		Psychiatric Treatment (Tratamiento Psiquiatrico)	YES (SI) NO
Cerebral Palsy (Paralisis Cerebral)	YES (SI) NO	Rheumatoid Fever (Fiebre Reumatica)	YES (SI) NO
Cleft Lip/Palate (labio leporino/Paladar Hendido)	YES (SI) NO	Sickle Cell Disease (Anemia de Celulas Falciformes)	YES (SI) NO
Congenital Heart Disease	YES (SI) NO	Stomach Ulcers (Ulceras Gastricas)	YES (SI) NO
(Enfermedades Congenitas del Corazon)		Thyroid Disease (Enfermedades de la Glandula Tiroides)	YES (SI) NO
Diabetes	YES (SI) NO	Tuberculosis (TB)	YES (SI) NO
Emphysema (Enfisema)	YES (SI) NO	Veneral Disease (Enfermedades Venereas)	YES (SI) NO
Epilepsy/Seizures (Epilepsia/Convulsiones)	YES (SI) NO	Other -Explain (Otra - Explique) : _____	

If you answered "YES" to any of the above questions, please explain:
(Si ha contestado "SI" a algunas de las preguntas anteriormente, por favor explique):

_____
_____
_____

To the best of my knowledge, all of the preceding answers are true and correct. If my child ever has a change in his/her health or his/hers medicines, I will inform the doctor/dentist as soon as possible.

Certifico que todas las preguntas anteriormente fueron contestadas veraz y correctamente. Si mi hijo(a), tiene un cambio de salud, o comienza a tomar algun medicamento nuevo, debere informarle al dentista/doctor lo antes posible.

X _____

Signature of Parent/Guardian ***Date***
Firma del Padre, Madre o Tutor Legal ***Fecha***

For Office Use Only

Medical History Reviewed By:

Comments: _____
_____
_____

_____ _____ _____
Reviewer's Name (print) *Signature of Reviewer* *Date*

Please complete information on the reverse side of this form. Favor de completar la informacion al dorso de esta pagina.

REVISED 01/22/2018