

Health Care for the Homeless

INFORMATION RESOURCE CENTER

888/429-3300 • Fax 518/439-7612

#16. DENTAL FORMS

Dental clinic client survey (*TRA 6*)
Dental problems (*HPH 9*)
Dental professional volunteer application (*TRA 1*)
Dental program office survey (*TRA 10*)
Dental record (*CAM 9*)
Dental record (*TRA 9*)
Health history for dental referrals (*BAL 34*)
Dental referral (*THU 3*)
Medical/dental history (*TRA 8*)
Plan of treatment / *Plan de tratamiento* – Dental (*CAM 10*)

TRAVELERS AID SOCIETY OF RHODE ISLAND

HEALTH SERVICES

DENTAL CLINIC CLIENT SURVEY

Date: _____

Gender: ~~male~~ _____ female _____

Race: white _____ black _____ Hispanic _____ other (please specify) _____

How long, in weeks, did you wait to see the dentist? _____

the hygienist ? _____

How long did you wait to be treated today ? 15 minutes or less _____

30 minutes _____ one hour or more _____

In your opinion, was the medical history too detailed _____ or appropriate in length _____

Was your chief complaint treated in your first visit ? _____ yes _____ no

Were instructions regarding the care of your mouth or teeth given to you before you left the clinic ? _____ yes _____ no

Were you comfortable or encouraged in asking questions ? _____ yes _____ no

If you saw the dentist today, was a return appointment made for you to have your teeth cleaned ? _____ yes _____ no Did you want an appointment? _____ yes _____ no

Were you treated courteously during your visit by:

the nurse who reviewed your medical history _____ yes _____ no

the dental assistant _____ yes _____ no

the hygienist _____ yes _____ no

the dentist _____ yes _____ no

Do you have any comments that you wish to make ?

HOMELESS PERSONS HEALTH PROJECT

COUNTY OF SANTA CRUZ
HEALTH SERVICES AGENCY

CHART # _____
ISSUE # _____

CLIENT NAME _____ DATE: _____

Please draw a line through any order(s) which do not pertain to your client.

DENTAL PROBLEMS

S: _____

O: _____

A1 DENTAL PROBLEMS: _____

A2 REFERRED TO APPROPRIATE AREA AGENCIES: _____

MediCal 800 number

CHDP

Cabrillo College dental cleaning

Assessed for knowledge deficits

Instructed re: proper oral hygiene; soft toothbrush; flossing

Advised of resources for oral hygiene maintenance; HPHP offers free toothbrush/toothpaste; may use baking soda for brushing

Educate re: criteria that must be met for county emergency DDS referral

P Client to follow-up as above. Client to initiate contact with HPHP as necessary for follow-up

SIGNED _____ Page # _____



TRAVELERS AID SOCIETY OF RHODE ISLAND
177 UNION STREET
PROVIDENCE, RI 02903
(401) 521-2255
FAX (401) 421-7410

HEALTH CARE SERVICES PROGRAM
DENTAL PROFESSIONAL VOLUNTEER APPLICATION

OFFICE COPY

Social Security # _____ Date of Birth ____ / ____ / ____
Name _____ Employer _____
Address _____ Address _____
City _____ Zip _____ City _____ Zip _____
Telephone _____ Telephone _____
Fax # _____

Professional License # _____

Please enclose evidence or current copies of the following:

- Copy of RI professional license
- Copy of cover page of malpractice insurance
- Copy of CPR certification
- Evidence or declination of HBV vaccination
- Date of last PPD (within last 12 mos.)
- Evidence of Measles/Rubella Vaccine

Please identify your profession by circling one of the following.

DDS, DMD, RDH, CDA, OTHER _____

How did you hear about the program? _____

What is your specialty? _____ Additional skills you would like to contribute _____

Are you bi-lingual? _____ language _____ If dentist, are you willing to supervise auxiliary personnel? _____

PROFESSIONAL REFERENCE

Name: _____ Address: _____
City: _____ Zip: _____

Please circle preferred time you would like to volunteer:

M T W TH F morning _____ afternoon _____

We are asking for a minimum of 3 hours four times a year. If you are able and willing to do more we can discuss details. The need is great.

Signature _____

Date _____

INTEROFFICE USE ONLY
OR Date: _____
Start Date: _____

1 M 10-1
TRA 10-1

TRAVELERS AID SOCIETY OF RHODE ISLAND
HEALTH CARE SERVICES
DENTAL PROGRAM OFFICE SURVEY
(401) 521-2255

A. 1. Survey date: _____ Evaluator: _____
Identification

B. 1. Is adequate convenient parking available? _____ Yes _____ No
General E G A NI P
2. Condition of building: _____
3. Neighborhood: _____ Rural _____ Suburban _____ City
4. Neighborhood: _____ Commercial _____ Residential _____ Industrial _____ Farm
5. Is there handicapped access? _____ Yes _____ No
6. Is there access to public transportation? _____ Yes _____ No

C. 1. Is there adequate seating? _____ Yes _____ No
Waiting Room 2. Overall appearance of area: _____ E _____ G _____ A _____ NI _____ P

D. 1. Is a separate business area present? _____ Yes _____ No
Business Area 2. Is the office computerized? _____ Yes _____ No
3. Cleanliness and neatness of area: _____ E _____ G _____ A _____ NI _____ P

E. 1. What is the waiting time for appointments (in weeks)?:
Appointments New Patient: _____ weeks
Continuing care: _____ weeks
2. How are emergency visits handled:
_____ seen immediately
_____ same day
_____ other: _____

F.
Record Keeping

	<u>Yes</u>	<u>No</u>
1. Are medical "alerts" conspicuously noted on the record when indicated?	_____	_____
2. Is there a complete, current medical history in the record (updated at least every six months or at recall)?	_____	_____
3. Indicates necessary premedications and current meds:	_____	_____
4. Is the following information recorded:		
blood pressure	_____	_____
existing restorations	_____	_____
caries	_____	_____
missing teeth	_____	_____
prosthetic appliances	_____	_____
soft/hard tissue exams	_____	_____
periodontal status	_____	_____
problems/diagnosis	_____	_____
sequential treatment plan	_____	_____
5. Do entries include:		
date of service	_____	_____
tooth and surfaces	_____	_____
drugs given/administered/prescribed	_____	_____
doctor's signature	_____	_____
6. How many records were reviewed? _____		
7. How many x-ray films were reviewed? ___ FMS ___ BW sets ___ Pan ___ PA's		
8. The quality of the x-rays is: ___ E ___ G ___ A ___ NI ___ P		
9. Appropriate x-rays taken/obtained for all new patients? Describe: _____	___ A ___ U ___ S ___ N	
10. Are all x-rays clearly dated and identified?	___ A ___ U ___ S ___ N	
11. Does the record system contain a specific area to indicate:	<u>Yes</u>	<u>No</u>
Updated medical history?	_____	_____
Periodontal pocket depths?	_____	_____
Tooth charting?	_____	_____

G.
Medical Emergencies

	<u>Yes</u>	<u>No</u>
1. Is there a medical emergency kit?	_____	_____
2. Are the medications in the kit current?	_____	_____
3. Is portable oxygen or Ambu bag available?	_____	_____
4. Is the dentist currently certified in CPR?	_____	_____
5. Is the staff currently certified in CPR?	_____	_____

**H.
Radiographs
and
Mercury Safety**

1. Lead aprons used? Yes No
 2. How many x-ray machines are in the office?
Describe: _____ machines
 3. Are radiation badges worn by clinical staff? Yes No
 4. Are closed amalgam capsules used? Yes No
 5. Is scrap amalgam stored appropriately? Yes No
 6. Is the environment free of mercury? Yes No
-

**I.
Anesthesia**

1. Type of anesthesia offered: Local anesthesia None
 Nitrous Oxide Oral premedication
 IV Sedation General Anesthesia
 2. Are aspirating syringes used? Yes No
 3. Are disposable needles used? Yes No
 4. Is there a recovery room for general anesthesia or IV sedation? Yes No N/A
-

**J.
Sterilization,
Asepsis &
Infection Control**

1. Are all instruments *sterilized* that can be? Yes No
 By what method(s): _____
 Steam autoclave Chemiclave
 Dry heat (at least 340F for 60 min)
2. What, if anything, is "cold sterilized" (disinfected)?

3. Are disposable supplies always discarded after single use?
 (such as prophy cups, saliva ejectors, etc.) Yes No
4. Are all instruments stored in a sealed container after sterilization? Yes No
5. Are handpieces sterilized after each patient? Yes No
6. Is there an OSHA training schedule available? Yes No
7. Is there an OSHA log book containing employees medical records? Yes No
8. Are gloves worn for all patients? Yes No
9. Are masks worn for all patients? Yes No
10. Is eye protection worn for all patients? Yes No
11. Are there points of use sharps disposal containers? Yes No
12. Are there containers for the disposal of medical waste? Yes No
13. Is Medical Waste stored in an appropriate area? Yes No
14. Is there a log book for sterilizer checks? Yes No

K.

Treatment Rooms

- 1. Total number of treatment rooms/operatories: _____ rooms
- 2. Is there adequate privacy? _____ Yes _____ No
- 3. Is the lighting adequate? _____ Yes _____ No
- 4. Condition of equipment: _____
- 5. Overall appearance of rooms: _____
- 6. Age of equipment in years: _____ 0-10 _____ 11-20 _____ 21-30
 _____ 30-40 _____ >40

L.

Staff

1. Number of dentists practicing at this office: _____

1a. Names of dentists:

Specialty

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

1b. Number of hygienists at this office: _____

_____ FT _____ PT _____ RDH hrs/wk

1c. Name of Dental Coordinator: _____

2. How many non-DDS, non-RDH staff? _____ FTE auxiliary/office staff
E G A NI P

3. Appearance of staff: _____

4. Friendliness of staff: _____

5. Professional behavior of staff: _____

**M.
Miscellaneous**

1. Evaluators overall impression of acceptability:

- Outstanding _____
- Excellent _____
- Good _____
- Fair _____
- Unacceptable _____

Comments: _____

N. Explanation of Symbols:

- E Excellent
- G Good
- A Average/Always
- NI Needs Improvement
- P Poor
- N Never
- S Seldom
- U Usually

CAM 9

CAMILLUS HEALTH CONCERN DENTAL RECORD

NAME _____
DATE _____
BIRTHDAY _____
SEX _____
ALERT
CHC # _____

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. ARE YOU UNDER THE CARE OF A PHYSICIAN?
(ESTA USTED BAJO EL TRATAMIENTO DE ALGÚN MEDICO)
REASON (RAZÓN): _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. ARE YOU TAKING ANY MEDICINE OR DRUGS?
(ESTA TOMANDO ALGÚN MEDICAMENTO O DROGA)
LIST (NÓMBRELOS): _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. HAVE YOU BEEN HOSPITALIZED IN THE LAST 5 YEARS?
(HA ESTADO USTED HOSPITALIZADO EN LOS PASADOS 5 AÑOS)
WHY? (POR QUE?): _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. ARE YOU ALLERGIC TO ANYTHING (DRUGS, FOODS)?
(ES USTED ALÉRGICO A ALGO (MEDICINAS, COMIDAS)
LIST (NÓMBRELOS): _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. HAVE YOU EVER HAVE ANY OF THE FOLLOWING?
(HA TENIDO USTED ALGUNO DE LOS SIGUIENTES) | | |
| HEART TROUBLE (PROBLEMAS DEL CORAZÓN) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| RHEUMATIC FEVER (FIEBRE REUMÁTICA) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| HIGH BLOOD PRESSURE (PRESIÓN ALTA O BAJA) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| LIVER DECEASE (HEPATITIS) (PROBLEMA DEL HÍGADO) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| EPILEPSY (SEIZURES) (EPILEPSIA) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| CANCER _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| TUBERCULOSIS _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| ANEMIA _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| BLOOD DISEASE (PROBLEMAS DE SANGRE) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| ASTHMA (ASMA) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| A.I.D.S.-C.I.D.A. (S.I.D.A) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. DO YOU SMOKE? PACKS PER DAY _____
(USTED FUMA? PAQUETES POR DÍA) | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. ARE YOU PREGNANT?
(ESTA USTED EMBARAZADA?) | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. IS THERE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK WE KNOW ABOUT, OR IS THERE ANY ACTIVITY YOUR DOCTOR SAYS YOU CAN NOT DO?
(SI HAY ALGUNA ENFERMEDAD, CONDICIONA O PROBLEMA NO MENCIONADO ARRIBA QUE USTED PIENSE DEBAMOS SABER, O ALGUNA ACTIVIDAD QUE SU DOCTOR NO LE PERMITE HACER?)
IF SO, EXPLAIN (SI ES ASÍ EXPLIQUE) _____ | | |

DENTAL HISTORY (HISTORIA DENTAL)

- REASON FOR VISIT? (RAZÓN DE SU VISITA) _____
- LAST DENTAL VISIT? (ULTIMA VISITA) _____ LAST COMPLETE EXAM (FECHA, EXAMEN COMPLETO) _____
- DO YOU PREFER A LOCAL ANESTHETIC (NOVOCAINE) FOR MOST DENTAL TREATMENT? YES _____ NO _____
(PREFIERE USTED ANESTESIA LOCAL (NOVOCAÍNA) PARA LA MAYORÍA DE SU TRATAMIENTO DENTAL)
- HAVE YOU EVER HAD ANY SERIOUS TROUBLE ASSOCIATED WITH PREVIOUS DENTAL TREATMENT?
(HA TENIDO USTED PREVIAMENTE ALGÚN PROBLEMA SERIO RELACIONADO CON EL TRATAMIENTO DENTAL)
- DOES DENTAL TREATMENT MAKE YOU NERVOUS? NO _____ SLIGHTLY _____ MODERATELY _____ EXTREMELY _____
(EL TRATAMIENTO DENTAL LO PONE NERVIOSO?) (NO) (UN POCO) (BASTANTE) (EXTREMADAMENTE)
- HAVE YOU EVER BEEN TREATED FOR PERIODONTAL DISEASE (GUN DISEASE, PYORRHEA, TRENCH MOUTH) (HA SIDO TRATADO POR ENFERMEDAD PERIODONTAL (ENFERMEDAD DE ENCIAS, PIORREA, GINGIVITIS ULCERATIVA) _____
IF YES WHEN (SI ES ASÍ CUANDO) _____

Signature (Firma) _____

Date (Fecha) _____

Dental Record

Name _____

SS# _____

DOB _____

Allergies: _____

Examination

Findings: Normal = (-); Abnormal = (+)

Date: _____

Comments

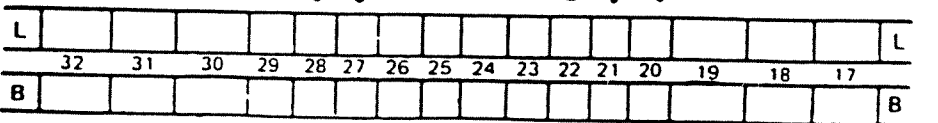
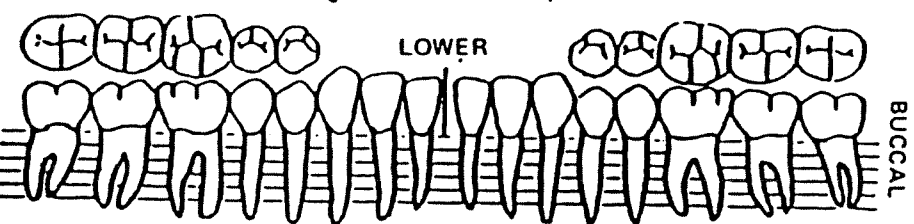
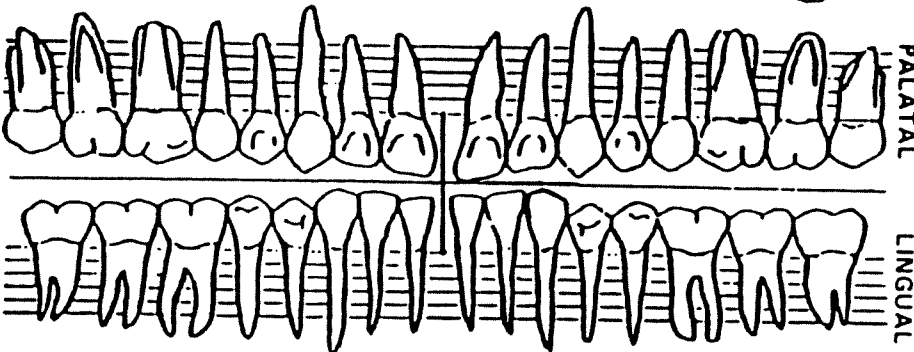
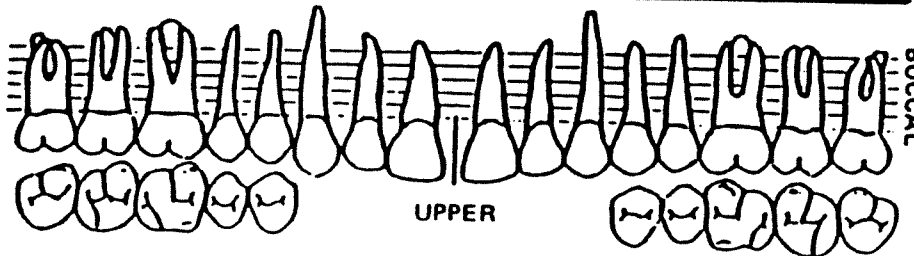
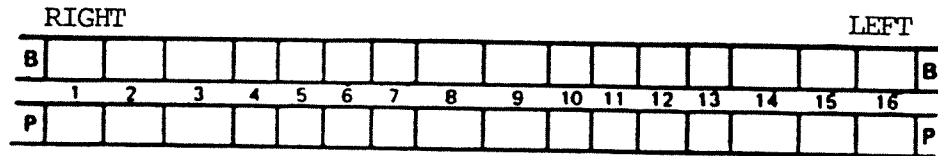
General Appraisal	-	+
Head (skin, face, eyes)	-	+
Lips	-	+
Neck (Nodes, glands)	-	+
Oral soft tissue	-	+
Periodontium	-	+
Teeth	-	+

Occlusion: _____

Evaluation: Specific Presenting Problem: _____

Dental Chart

Caries in red, restorations in blue



RIGHT

LEFT

Treatment Plan:

A. Immediate Dental Need/s.

1.

2.

B. Routine Dental Need/s.

1.

2.

3.

4.

5.

6.

7.

8.

ALERT! _____

HEALTH HISTORY FOR DENTAL REFERRALS

CLIENT NAME: _____ HCH#: _____

PROVIDER: _____ DATE: _____

HAS CLIENT HAD ANY OF THE FOLLOWING? INDICATE WITH A CHECK MARK (✓) OR X.
(EXPLAIN TREATMENT FOR ANY CONDITIONS PRESENT).

- _____ HEART PROBLEM
- _____ HEART MURMUR. IF YES, WAS CLIENT PROVIDED WITH SBE PROPHYLAXIS? _____
- _____ HIGH BLOOD PRESSURE
- _____ FAINTING OR DIZZINESS
- _____ CIRCULATORY PROBLEMS
- _____ ASTHMA
- _____ COPD OR OTHER PULMONARY CONDITION
- _____ KIDNEY DISEASE
- _____ DIABETES
- _____ ARTHRITIS
- _____ EPILEPSY OR SEIZURES
- _____ SPEECH PROBLEMS
- _____ VISION OR EYE PROBLEMS
- _____ DEAFNESS OR HEARING PROBLEMS
- _____ USES WHEELCHAIR OR CRUTCHES
- _____ NEEDS ASSISTANCE TO WALK
- _____ SINUS PROBLEMS
- _____ PREGNANCY
- _____ SICKLE CELL DISEASE
- _____ EXCESSIVE BLEEDING

_____ HEPATITIS SIGNIFICANT BLOOD WORK RESULTS _____

_____ HIV IF NO, DATE OF LAST TEST _____
RISK FACTORS FOR HIV _____
(IF HIV+, SEND COPY OF CBC, CD4, CHEM, PT/PTT WITHIN PAST MONTH. REFER TO HIV CLINIC)

_____ TUBERCULOS DATE OF LAST TB TEST OR CXR _____

_____ SEXUALLY TRANSMITTED DISEASE

_____ ALLERGY TO MEDICATION _____ ALLERGY TO FOOD _____ ALLERGY TO NOVACAINE OR NUMBING AGENT

PLEASE NOTE ANY ANTIBIOTIC AND/OR ANALGESIA PROVIDED TO CLIENT:

I AUTHORIZE RELEASE OF THE ABOVE INFORMATION TO THE DENTAL CLINIC. _____
(CLIENT SIGNATURE)

THUNDERMIST HEALTH ASSOCIATES, INC.
383 ARNOLD STREET
WOONSOCKET, RI 02895

H.C.H. DENTAL REFERRAL FORM

REFERRAL DATE: _____

PATIENT NAME: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

MEDICAL RECORD #: _____

REASON FOR REFERRAL: _____

FOR DENTIST/HYGIENIST USE ONLY:

DENTAL CARE PLAN: _____

NEXT VISIT: _____

COMMENTS: _____

TRAVELERS AID SOCIETY OF RI
177 UNION STREET
PROVIDENCE, RI 02903

TKA 8

REVIEWED BY _____ DATE _____
REVIEWED BY _____ DATE _____
REVIEWED BY _____ DATE _____
REVIEWED BY _____ DATE _____

MEDICAL/DENTAL HISTORY

PATIENT NAME: _____
Last First Middle Initial

TODAY'S DATE: _____
Mo. Day Year

The following information is considered confidential medical information. It may be necessary to share this with your case worker in order to coordinate services.

If Yes, Explain

Answer the following questions by circling Y(Yes) or N(No) to which ever applies:

Have you been hospitalized or had any serious illness? Y N

Has there been any changes in your general health within the past year? Y N

Do you have allergies or bad reactions to any medications, prescription, or over the counter? Y N

If yes, list _____

Do you take or apply any medicine (including birth control pills)? Y N

If yes, list (including over the counter) _____

Do you have a physician? Y N Name: _____

Address: _____

Date of last physical: Mo. Yr. Place of exam: _____

Do you have a dentist? Y N Name: _____

Address: _____

Date of last dental exam: Mo. Yr. Last dental X-rays: _____

FEMALES ONLY: Are you pregnant, or do you suspect you may be? Y N Due date: _____

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?:

MEDICAL

EXPLAIN

EXPLAIN

- Rheumatic Fever Y N
- Heart Murmur Y N
- Valve Disorder(heart) or Surgery . . Y N
- Artificial Joint Replacement Y N
- Sugar Diabetes Y N
- Yellow Skin or Eyes Y N
- Hepatitis Y N
- Tuberculosis Y N
- High/Low Blood Pressure Y N
- Kidney Problems Y N
- Seizures, Epilepsy Y N
- Thyroid Disorder Y N
- Heart Trouble, Surgery, Angina, etc. Y N
- Pacemaker Y N
- Stroke Y N
- Drug Abuse problem Y N
- Alcohol Problem Y N
- Treatment for Substance Abuse . . . Y N
- Do you smoke? # of packs/day ___ Y N

- Blood Transfusion Y N
- Blood Refused for Donation Y N
- Bleeding Disorder, i.e. Hemophilia Y N
- Benign Tumor or Cancer Y N
- Radiation Therapy Y N
- Breathing difficulties Y N
- Heartburn, Stomach disorders Y N
- Hearing problems Y N
- Eye problems Y N
- Sexually Transmitted Disease Y N
- Last treated _____
- Intimate contact with anyone at risk for AIDS Y N
- IV Drug User Y N
- Multiple Sex Partners Y N
- Intimate contact with bisexuals Y N
- Emotional problems Y N
- Received treatment for emotional problem . . Y N
- If so, where? _____

DENTAL

EXPLAIN

EXPLAIN

- Do you have pain? Y N
- If yes, where? _____
- Is the pain constant? Y N
- Is the pain associated with hot/cold or sweets? . . Y N
- Do you take something for the pain? Y N
- If yes, what? _____
- Is there anything unusual about your mouth? Y N
- Tooth pulled? Y N
- Fillings? Y N
- Removable teeth? Y N
- Bad experiences with previous dental treatment? . . Y N
- If so, explain _____

- Do you brush your teeth? Y N
- If so, how often? _____
- Do you need a tooth brush, tooth paste, floss? Y N
- Do you floss? Y N
- Do you know how to floss? Y N
- Do your gums bleed? Y N
- If yes, when? _____
- Root canal therapy? Y N
- Do you have any questions? Y N

I have answered the above questions honestly and hereby grant permission to administer dental care to: Travelers Aid Society of RI
177 Union Street, Providence, RI 02903.

Signature of Patient: _____

Date: _____

Signature of Responsible Adult if Under 16: _____

HEALTH HISTORY FOR DENTAL REFERRALS

CLIENT NAME: _____ HCH#: _____

PROVIDER: _____ DATE: _____

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(EXPLAIN TREATMENT FOR ANY CONDITIONS PRESENT).

- _____ HEART PROBLEM
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(CLIENT SIGNATURE)

PLAN OF TREATMENT (PLAN DE TRATAMIENTO)

PROBLEMS (PROBLEMAS)	TREATMENT (TRATAMIENTO)	COST (COSTO)	FINAL TREATMENT (TRATAMIENTO FINALIZADO)

