COLUMBIA UNIVERSITY
College of Dental Medicine

Student Dental Plan
Open to all students and their families

Columbia Dental Associates
Columbia Dental Associates is sponsored by
The Columbia University College of Dental Medicine

All dental care is provided by dentists enrolled in a post-graduate fellowship program. Columbia Dental Associates is committed to providing the highest quality care in a pleasant, convenient atmosphere.

Coverage
Semi-annual examinations
Radiographs as needed
Semi-annual prophylaxis (dental cleanings)
Emergency services during office hours
25% discount from Columbia Dental Associates (CDA) fees on all services not covered above (comparable to 50% off for the same procedure at competitive dental offices outside the CDA Group Practice).

Enrollment
Fill out the student membership form to the right
Include check for $180 per member payable to:
Columbia Dental Associates or use your credit card (once received, we will call you to get your 3 digit security code number).

Mail form and payment to:
Student Dental Plan
630 W. 168th Street, P&S Box 20
New York, NY 10032

Upon receipt of payment, your name will be included on a membership list sent to the clinics (you will not receive a card).

To schedule an appointment at a location convenient for you, call between 9 am to 4 pm, Monday through Friday. Mention that you are a Student Dental Plan member and your name is on the membership list:

Morningside Campus Facility
1244 Amsterdam Avenue (near 121st Street) 212-865-8467

Health Science Campus Facility (Vanderbilt Clinic)
622 West 168th Street, 8th Floor 212-305-9053/9054

The enrollment period begins August 1 and continues through January 31. All memberships terminate July 31 regardless of the date of enrollment.

Questions
We would be happy to discuss the Student Dental Plan in more detail with you. Call us at 212-305-0763 or e-mail us at cdp@columbia.edu (indicate it is regarding the Student Dental Plan) or stop by at P&S 3-454F and we will gladly answer any questions you may have.

Additional Services
Oral & Maxillofacial Surgery in Faculty Practices
Students are offered a 30% reduction on faculty fees for Oral and Maxillofacial Surgery. Present your student ID to receive the discount.

Appointments for oral surgery can be made at the following locations which can all be accessed via shuttle buses. The first two facilities listed provide sedation in addition to local anesthesia for surgical procedures:

Columbia Presbyterian Medical Center
Broadway & 168th Street (A, C, 1 and 9 subway lines)
7th Floor-faculty practice, Vanderbilt Clinic Building
212-305-4552

Columbia Presbyterian Eastside
16 East 60th Street at Madison Avenue 212-326-8520

Columbia Dental Morningside Associates
1244 Amsterdam Avenue near 121st Street 212-961-1266

* Typical sequence for wisdom tooth extraction:
Visit 1: Pre-surgery consult with surgeon, X-rays taken
Visit 2: Teeth extraction
Visit 3: Post-extraction follow-up

CDA Membership Form

Student name
Local address APT #
City STATE ZIP
Telephone:
Date of birth:
College enrolled in:
Year (check one)
☐ Freshman ☐ Sophomore ☐ Junior
☐ Senior ☐ Graduate ☐ Other
☐ Check enclosed (payable to Columbia Dental Associates)
☐ Please charge to:
Mastercard/Visa #
Expiration date
Signature

Member 2
Name
Date of birth Age
Sex: ☐ Male ☐ Female

Enclose $180 per member annual fee
Mail to:
Student Dental Plan
630 West 168th Street, P&S Box 20
New York, New York 10032
Columbia University Health Care at Columbia University College of Dental Medicine

Patient registration Form/ Formulario de Registro del Paciente

Patient Information/ Informacion del Paciente: Chart / Expediente _______ Date of Birth/ Fecha de Nacimiento __/__/____

Patient Name / Nombre del Paciente ______________________________________________________ Gender / Sexo M __ F __

Patient Street Address / Direccion del Paciente
Street / Calle ________________________________________________________________________ Apt / Apt ________________________________________________________________________

City / Ciudad ________________________________________________________________________ State / Estado ________________________________________________________________________ Zip code /Codigo Postal ________________________________________________________________________

Patient Home Phone Number / Telefono Residencial _______________________________________

Emergency Contact / Persona en caso de Emergencia _______________________________________

Telephone Number / Numero de Telefono __________________________ Relationship / Parentesco ________________________________________________________________________

Do you have a Doctor? / Tiene un Doctor? __________________________ Phone / Telefono ________________________________________________________________________

Reason for today's visit? / Razon de la visita de hoy? ________________________________________________________________________

(Please provide insurance cards for verification / Por favor, provea su tarjeta de seguro para verificacion)

NYS Medicaid _______ Manage Care Medicaid _______ Columbia Student _______ Self Pay _______ ________________________________________________________________________

Health History/ Historial de Salud

Heart Attack / Ataque de Corazon: Yes / No Si / No

Stroke / Hemorragia Cerebral: Yes / No Si / No

High Blood Pressure / Hipertension: Yes / No Si / No

Diabetes Diet Control / Diabetes Dieta controlada: Yes / No Si / No

Diabetes Insulin Dept / Diabetes Dependiente de Insulina: Yes / No Si / No

Heart murmur / Soplo: Yes / No Si / No

Cancer / Cancer: Yes / No Si / No

HIV / VIH: Yes / No Si / No

Asthma / Asma: Yes / No Si / No

Are you Pregnant? / Esta usted Embarazada?: Yes / No Si / No

If yes, how long? / Si contest Si cuanto meses ________________________________

Medications Prescription / Non Prescription / Medicamentos: ________________________________

Allergies to any Medication / Alergico a Medicamento: ________________________________

X ________________________________ Date / Fecha ________________________________

Signature of Patient / Firma del Paciente
COLUMBIA UNIVERSITY HEALTH CARE AT
COLUMBIA UNIVERSITY COLLEGE OF DENTAL MEDICINE
CONSENT TO DENTAL TREATMENT

You are requested to read the following paragraphs and to sign your name in the appropriate place if you consent to treatment of yourself or any minor patient named below at the Dental Clinics of the Columbia University Health Care Inc.

I hereby consent to the operations, procedures, techniques and clinical photographs that the dentists in attendance at Columbia University College of Dental Medicine deem necessary for my treatment or the treatment of the minor patient named below. I also hereby consent that any or all operations, procedures, and techniques may be rendered by a student(s), resident and/or faculty member at the School. I agree to abide by all the rules and regulations of Columbia University and Columbia University Health Care Inc.

I understand that prior to any operation, procedure, technique, or taking of any clinical photograph, I will be advised about it by the student and/or faculty member responsible for my care, that I may ask questions concerning it, and that I may revoke this consent before such treatment is provided. I further understand that post-operative complications (for example, bleeding, pain, swelling, loss of teeth) may be a normal consequence of the treatment rendered.

I hereby authorize and direct the above named, having treated me or my dependent, to release to government agencies, insurance carriers, or others who are financially liable for my or my dependent care, all information needed to substantiate payment for such care and to permit representatives thereof to examine and make copies of all records relating to such care.

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

I further understand that I am free to withdraw my consent to treatment at any time, and this consent will remain in effect until such time that I choose to terminate it.

I have received the General Dental Clinic Information, Patient Bill of Rights and Responsibilities and have read and understand the Consent to Dental Treatment statements.

Patient’s Name: ____________________________

For whom consent for treatment is granted

Signature of Patient or Parent or Guardian: ____________________________ Date: ____________________________

Relationship to Patient (If Parent or Guardian): ____________________________

Witness: ____________________________ Date: ____________________________

Patients have a right to and responsibility for:

1. Understand these rights. If necessary we will supply assistance and an interpreter.
2. Receive treatment without discrimination as to color, religion, sexual orientation, disability or source of payment.
3. Receive considerate and respectful care in a clean and safe environment.
4. Receive emergency care if needed.
5. Be informed of the name and position of the persons rendering care and names and position of administrative staff.
6. Receive complete information about the dental diagnosis, treatment, and prognosis.
7. Receive all the information needed for them to give informed consent including possible risks and benefits.
8. Refuse treatment and be told of the possible consequences.
9. After a full explanation they have a right to refuse to take part in research.
10. Privacy and confidentiality of all information regarding their care.
11. Participate in decisions regarding their care.
12. Obtain their dental record for which they may be charged a reasonable fee. They cannot be denied a copy solely because of inability to pay.
13. Receive a receipt for and explanation of all charges.
14. Complain without fear of reprisals. If they are not satisfied, they may address their concerns to the section administrator of their area of care. If they are still not satisfied, they may call the Office of Clinic Administration.
For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

1. Are you in good health? ¿Está usted bien de salud? ¿Goza usted de buena salud? .................................................. Yes (Sí) No

2. Has there been any change in your general health within the past year? ¿Durante el último año ha observado usted cualquier cambio en su salud general? .................................................. Yes (Sí) No

3. My last physical examination was on El examen físico más reciente que me hicieron fue el .................................................. Yes (Sí) No

4. Are you now under the care of a physician? ¿Está usted bajo el cuidado de un(a) médico(a) ahora? Yes (Sí) No If so, what is the condition being treated? En ese caso, ¿para qué consultó usted a su médico?

5. The name and address of my physician(s) is ¿Cómo se llama? ¿Cuál es la dirección de su consultorio?

6. Have you had any serious illness, operation, or been hospitalized in the past 10 years? ¿Ha sufrido usted alguna vez de una enfermedad grave, ha sido operado(-a), o ha estado usted hospitalizado(-a) por cualquier razón durante los últimos diez años? .................................................. Yes (Sí) No If so, what was the illness or problem? En ese caso, ¿cuál fue la enfermedad o problema?

7. Are you taking any medicine(s) including non-prescription medicine? ¿Toma usted alguna(s) medicina(s) o drogas incluyendo cualquiera que no requieren recetas? .................................................. Yes (Sí) No If so, what medicine(s) are you taking? En ese caso, ¿cómo se llama(n) la(s) medicina(s)?

8. Do you have or have you had any of the following diseases or problems? ¿Padece usted o ha padecido usted alguna vez de cualquiera de las enfermedades o problemas que siguen?

   a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease Yes No

   b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) .................................................. Sí No

   b. Enfermedad cardiovascular (problemas con el corazón, ataque al corazón, angina, insuficiencia coronaria, obstrucción coronaria, presión arterial alta, arteriosclerosis, ataque de parálisis) Yes No

   1. Do you have chest pain upon exertion? ¿Le da dolor en el pecho al hacer ejercicio? Yes (Sí) No

   2. Are you ever short of breath after mild exercise or when lying down? ¿Le falta la respiración a usted después de hacer ejercicios o cuando está acostado(-a)? Yes (Sí) No

   3. Do your ankles swell? ¿Se le hinchan a usted los tobillos? Yes (Sí) No

   4. Do you have inborn heart defects? ¿Tiene usted defectos cardíacos congénitos? Yes (Sí) No

   5. Do you have a cardiac pacemaker? ¿Tiene usted un marcapasos cardíaco? Yes (Sí) No

   c. Allergy Alergia Yes (Sí) No

   d. Sinus trouble Problemas con los pasajes nasales (sinusitis) Yes (Sí) No

   e. Asthma or hay fever Asma o fiebre del heno Yes (Sí) No

   f. Fainting spells or seizures Desmayos, mareos, o ataques epilépticos Yes (Sí) No

   g. Persistent diarrhea or recent weight loss Diarrea continua y persistente o una pérdida reciente de peso Yes (Sí) No
h. Diabetes
i. Hepatitis, jaundice or liver disease Hepatitis, Híperacidida o enfermedad del hígado
j. AIDS or HIV infection SIDA [AIDS] o infección causada por el virus HTLV-III [HIV]
k. Thyroid problems Problemas de tiroides
l. Respiratory problems, emphysema, bronchitis, etc. Problemas al respirar, enfisema, bronquitis, etc.
m. Arthritis or painful swollen joints Artritis o articulaciones hinchadas dolorosas
n. Stomach ulcer or hyperacidity Úlceras gástricas o hiperacididad
o. Kidney trouble Problemas con los riñones
p. Tuberculosis
q. Persistent cough or cough that produces blood ¿Tiene usted una tos persistente o al toser, ¿Arroja usted sangre?
r. Persistent swollen glands in neck Glándulas hinchadas constantemente en el cuello
s. Low blood pressure Presión arterial baja
t. Sexually transmitted disease Enfermedades contraidas por medio del contacto sexual
u. Epilepsy or other neurological disease Epilepsia u otra enfermedad neurológica
v. Problems with mental health Problemas con la salud mental/psiquiátricos
w. Cancer Cáncer
x. Problems of the immune system Problemas del sistema inmunológico

9. Have you had abnormal bleeding? ¿Ha tenido usted flujo de sangre anormal?
   a. Have you ever required a blood transfusion ¿Ha tenido que hacerle alguna transfusión de sangre?
   b. Do you have any blood disorder such as anemia? ¿Tiene usted algún desorden sanguíneo como anemia?

11. Have you ever had any treatment for tumor or growth? ¿La han puesto en tratamiento contra un tumor o crecimiento?

12. Are you allergic or have you had a reaction to: ¿Es usted alérgico(-a) o ha reaccionado adversamente a:
   a. Local anesthetics anestésicos locales?
   b. Penicillin or other antibiotics penicilina u otros antibióticos?
   c. Sulfa drugs drogas de sulfona?
   d. Barbiturates, sedatives, or sleeping pills barbitúricos, sedativos, calmantes, o píldoras para dormir?
   e. Aspirin aspirina?
   f. Iodine yodo?
   g. Codeine or other narcotics codeina u otros narcóticos/drogas estupefacientes?
   h. Rubber Goods and/or Latex materiales de goma u/o guantes de Latex?
   i. Other otras cosas?

13. Have you had any serious trouble associated with any previous dental treatment? ¿Ha tenido usted alguna vez cualquier problema grave relacionado con cualquier tratamiento dental previo?
   If so, explain En ese caso, expliquen

14. Do you have any disease, condition, or problem not listed above that you think I should know about? ¿Tiene Ud. alguna enfermedad, condición o problemas que no se ha mencionado en la lista y que Ud. cree que debemos saber?
   If so, explain En ese caso, expliquen

15. Are you wearing contact lenses? ¿Lleva usted lentes de contacto?
16. Are you wearing removable dental appliances? ¿Lleva usted cualquier aparato dental removible?
17. Do you smoke or use any form of tobacco products? ¿Usted fuma o usa alguna forma de productos de tabaco?
   If yes, do you want to stop? ¿Si fuma, le gustaría dejar de fumar?
18. Have you ever used or are you using diet pills including Fen-Phen (Fenfluramine and Dexfenfluramine)? ¿Usó alguna vez ha tomado la pastilla Fen-Phen (Fenfluramine y Dexfenfluramine)?

Women

19. Are you pregnant? ¿Está usted embarazada/en estado?
20. Do you have any problems associated with your menstrual period? ¿Tiene usted algunos problemas asociados con su ciclo menstrual?
21. Are you nursing? ¿Da usted el pecho al niño (a la niña)?
22. Are you taking birth control pills? ¿Toma usted píldoras para el control de embarazo?

Chief Dental Complaint Principal queja dental

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<thead>
<tr>
<th>Signature of Patient</th>
<th>Date</th>
<th>Reviewed By</th>
<th>Date</th>
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<tbody>
<tr>
<td>Firma del (de la) paciente</td>
<td>Fecha</td>
<td>Revisado Por</td>
<td>Fecha</td>
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