Part I Patient Information

Patient Name: ______________________ Date of Birth: __________ Sex: _____ Race: _____

Address: ______________________ City: ______________ Zip: __________

Telephone/Home: ______________________ Work/Emergency: ______________________

I.D. Number: ______________________ Social Security Number: ______________________

Parents/Guardian/Spouse: ______________________

Head of Household: ______________________ Date of Birth: ______________________

Does the Patient have Medicaid? Yes: ____ No: ____ ______________________ *(Policy Number)*

Other Insurance/Medicaid HMO? ______________________ *(Company)* ______________________ *(Policy Number)*

Has the Patient completed the eligibility process for health department services? Yes: ____ No: ____

Has the Patient ever been to this dental clinic? Yes: ____ No: ____ Does the Patient receive a "free lunch"? Yes: ____ No: ____

When did the Patient last visit a dentist? ______________ *(Date)* ______________________ *(Dentist/Location)*

What dental work was done (i.e. exam,fillings,extrications, other)? ______________________

Who is the Patient's physician? ______________________ *(Physician's Name)* ______________________ *(Address)*

Last Office Visit: ______________________ *(Date)* Last Physical Examination: ______________________ *(Date)*

Part II Medical History

Please Circle **Yes** or **No**

Is the Patient in good health?........................ Yes No

If not, explain: ______________________

Is the Patient taking any medicine, drugs, herbs or non-prescription supplements? .... Yes No

Please list all: ______________________

____

Does the Patient use:

Alcohol.. Yes No
Tobacco .... Yes No
Recreational Drugs............................. Yes No

Is the Patient allergic to penicillin?.................. Yes No
Does the patient have any other allergies:............ Yes No

Medicines (list) ______________________
Latex or Rubber .... Yes No
Dental Anesthetic (numbing) .... Yes No

Any other allergies ______________________

Is the Patient pregnant?........................... Yes No

Is the Patient breast-feeding?...................... Yes No

Has the Patient had:

Cancer .... Yes No

Leukemia....................................... Yes No

Tumor.. Yes No

__________ *(Date)* __________ *(Physician/Oncologist)* __________ *(Surgery/Chemotherapy/Radiation)*

Does the Patient have:

Asthma... Yes No

Other Respiratory Problems....................... Yes No

(continued)

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(continued)

Does the Patient use an inhaler or medications
For breathing? .... Yes No
Does the Patient have HIV or AIDS? .... Yes No

Has the Patient ever had any of the following conditions:

Heart Disease .... Yes No
Heart Valve Replacement .... Yes No
Stroke .... Yes No
Heart Murmur .... Yes No
High Blood Pressure .... Yes No
Rheumatic Fever .... Yes No
Diabetes .... Yes No
Sickle Cell Anemia .... Yes No
Bleeding Disorders .... Yes No
Anemia .... Yes No
Hepatitis .... Yes No
Tuberculosis .... Yes No
Goiter/Thyroid/Glandular Conditions .... Yes No
Kidney Problems .... Yes No
Dialysis/Transplant .... Yes No
Epilepsy/Seizures .... Yes No
Arthritis/Joint Pain .... Yes No
Pain in Jaws/TMJ .... Yes No
Artificial Joint .... Yes No
Growth/Development Conditions .... Yes No
Birth Defects/Premature Birth .... Yes No
Developmentally Delayed .... Yes No
Hyperactivity/ADD/ADHD .... Yes No
Autism .... Yes No
Cerebral Palsy .... Yes No
Hearing/Speech Conditions .... Yes No
Psychiatric/Psychological Conditions .... Yes No
Sexually Transmitted Disease .... Yes No
Drug Addiction .... Yes No

Is there a history of any of these problems
In the past? .... Yes No

Is there anything else we should know? ______________________

____

Medical History Update

Date					
Signature					

Part III Consent

The information given in Parts I,II and II of this form is accurate to the best of my knowledge of belief.

Informal Consent

Problems arising from dental treatment are extremely rare but may include pain or infection. Not treating dental disease may have the same result. If a tooth cavity is very deep and the nerve and blood supply are affected, or if bone loss or swelling are present, the removal of the nerve of the tooth with local anesthesia, may be necessary. Please feel free to discuss any concerns you have with the Public Health Dentist.

I authorize the Public Heath Dentist to perform on my child or myself a dental examination and treatment such as cleaning, treatment of gum disease, fluoride and sealant applications, fillings with local anesthesia and other treatments as deemed necessary by the dentist.

Date: ______________________ Signature: ______________________
(Patient/Parent/Guardian)

Notice of Deemed Consent for HIV, HBV and HCV Testing

If one of our health care professionals, workers or employees should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with Human Immune deficiency Virus (HIV, the AIDS Virus) and for the presence of the Hepatitis B and Hepatitis C Viruses. A physician or other health care provider will tell you and that person the result of the test and provide counseling, if necessary.

If you should be directly exposed to blood or body fluids of one of our heath care professionals, workers or employees in a way that may transmit disease, that person's blood will be tested for infection with Human Immune deficiency Virus (HIV, the AIDS Virus) and for the presence of the Hepatitis B and Hepatitis C Viruses. A physician or other health care provider will tell you and that person the result of the test and provide counseling, if necessary.

Date: ______________________ Signature: ______________________
(Patient/Parent/Guardian)