SAMPLE Dental Consent and Medical History Form for an Adult

_____

(Name of Public Health Dental Hygienist and/or Program)

Please print in ink

Name: _____ _____

Date of Birth: _ _/_ _ /_ _ _ _ □ Male □ Female Email Address: _____

Address:

_____

(Street) (City/town) (State) (Zip Code

Phone: _____ Email: _____

Social Security Number __ __ __ -__ __- __ __ __ __ Adult/Long Term Care Facility _____

Please tell us *your* race:

□ American Indian/Alaskan Native □ Asian □ Black/African American □ Hispanic/Latino □ White □ Other

Health Information:

1. Are you taking any medication now? □ YES □ NO

If yes, please list both prescribed and over the counter medications that you take in the space below:

2. Has a dentist or physician ever told you that you need to take antibiotics (penicillin) before having dental treatment? □ YES □ NO

3. Please check any illnesses or conditions you have EVER had:

□ Alcohol abuse	□ Drug Abuse	□ Rheumatic Fever
□ Allergies to Medicine(s)	□ Epilepsy	□ Shingles
□ Anemia or blood problems	□ Glaucoma	□ Sinus problems
□ Any Heart Ailments	□ Heart Murmur	□ Stroke
□ Arthritis	□ Hepatitis A, B, C	□ Thyroid Problems
□ Artificial Joint	□ High Blood Pressure	□ Tuberculosis
□ Asthma	□ Immune system, HIV, AIDS, ARC	□ Ulcer or colitis
□ Cancer or Chemotherapy	□ Kidney problems	□ Use of tobacco, cigarettes, chew
□ Diabetes	□ Liver problems	□ Sexually Transmitted Disease
	□ Psychiatric care/emotional problems	

4. Do you have any other health conditions? □ YES □ NO

If yes, please list._____

5. Do you have any allergies? ***If yes***, please check all that apply: ☐ YES ☐ NO

☐ Penicillin ☐ Antibiotics ☐ Anesthetics ☐ Colophonium ☐ Aspirin ☐ Foods ☐ Latex ☐ Resins ☐ Other: _____

6. Do you have a dentist? ☐ YES ☐ NO

Name of dentist and office location: _____

When did you last see your dentist? _____

7. What do you do to take care of your teeth and gums?
☐ Daily tooth brushing ☐ Daily flossing ☐ Inter-dental stimulators ☐ Water jet device

8. Do you have any pain in your mouth today? ☐ YES ☐ NO

9. Do you have **DENTAL INSURANCE**? ☐ YES ☐ NO

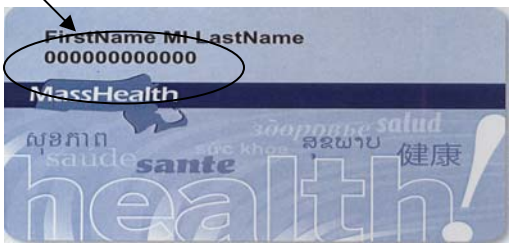
If you have dental insurance, please check which one and complete below:

☐ Blue Cross/Shield ☐ Delta Dental ☐ Mass Health/Medicaid Other _____

MassHealth

MassHealth RID Number

_____



Delta Dental, CMSP, or Other Dental Insurance

Company_____

Address_____

Subscriber_____

Subscriber ID #_____

Subscriber's Date of Birth _____ /_____/_____

Subscriber's Social Security Number_ _ _/_ _/_ _ _ _

Group/Policy #_____

Employer Name_____

I understand that the dental provider, _____, may use my health information for treatment, payment and health care operations. I have been given a copy of the Dental Provider's Notice of Privacy Practices.

I have read and understand the services that may be provided to me by this dental program and I consent to participate. I understand that I may continue to obtain dental care through any other provider. I understand that these services are not a substitute for an examination by a dentist. I understand that I should obtain a dental examination by a dentist within 90 days, if I have not had one, and if needed, this program will provide me with a list of dentists in my area.

I authorize the dental provider to consult with my medical provider(s) as may be appropriate to my health and the provision of dental care. If applicable, I authorize the dental program to provide a written summary of the examination and services provided to the official designee of my long term care facility or residential facility or institution.

If I have dental insurance, I authorize my insurance carrier to be billed for any services provided. I understand that this treatment may affect my future rights and benefits under my dental insurance. If I do not have dental insurance, I will pay the Dental Provider for all dental services that are charged to me.

X_____ Date: ___/___/___ **Relationship to Patient**: _____
Patient/Legal Representative Signature

_____ _____ _____
Print Name **Daytime Phone Number** **Cell Phone**