DELTA DENTAL

Delta Dental Mobile Program
Patient Information Form

Please fill out this form completely. If you have questions, please ask a Delta Dental staff member. Thank You!

Patient's Legal Name _____ **Birth Date** (mm/dd/yyyy) _____

School Attending _____ **Grade** _____ **Age** _____ **Sex** (circle) M F

Ethnicity: (circle) *White* *Black or African American* *Asian* *American Indian* *Hispanic/Latino* *Other*

Home Address _____
Mailing Address City State Zip

Phone Numbers: Home (_____) _____ Work (_____) _____

Cell (_____) _____

Parent/Guardian Name _____ Relation to patient _____

Emergency Contact: Person to contact in case of an emergency

Name _____ Relation to patient _____ Phone (____) _____

Income: Which of these best represents your annual household income? (circle one)

Less than $10,000 *$10,000-20,000* *$20,000-30,000* *More than $30,000*

Household Size: How many children age 21 or younger live in your household? _____

Dental History (Note: Dental visits should start at first tooth.)	Yes	No	
Is this the patient's first dental visit? Past or current dentist name_____			If no, how long has it been? (√) ___less than 2 years ___more than 2 years
Has the patient visited the ER/hospital for dental pain in the last year?			If "yes", how many times?
Has dental pain caused you or your child to miss school and/or work in the last year?			If "yes", circle – school work both How many times?

Medical History	Yes	No	Please Explain "yes" Answers
Patient's current physician _____ Date of last medical exam (mm/yy) _____			
Does the patient have a current medical condition?			
Is the patient taking any medications?			
Has the patient ever been hospitalized or had surgery?			
Does the patient have any allergies?			
Does the patient have any special needs that would require special arrangements for dental care? i.e. autism			
Is patient pregnant?			

Has the patient had a history of or had difficulty with the following? Check any that apply (√)

- ☐ AIDS / HIV
- ☐ Anemia
- ☐ Asthma
- ☐ Birth defects
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Diabetes
- ☐ Epilepsy/ seizures
- ☐ Excessive bleeding
- ☐ Other _____
- ☐ Fainting
- ☐ Heart problems
- ☐ Hepatitis
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Mono
- ☐ Rheumatic fever
- ☐ Tuberculosis

Please explain your answers: _____

Reason for Visit: Check any that apply (√)

☐ First examination ☐ Couldn't afford dental care ☐ Couldn't get appointment anywhere else

☐ Toothache/mouth pain/face swelling ☐ Other (specify)_____

Patient Behavior	Yes	No	
Does the patient brush daily?			
Does the patient drink soda pop or other sugar sweetened drinks daily (Kool-aid, fruit drink, Gatorade, sport drinks)?			
Is the patient using tobacco products (cigarettes, chewing tobacco, smokeless tobacco)?			
Does anyone in the household use tobacco products (cigarettes, chewing tobacco, smokeless tobacco)?			

Insurance: Please circle any that apply. If Medicaid or private dental insurance, please indicate Medicaid number or policy number in the space provided.

MUST PROVIDE A COPY OF YOUR DENTAL INSURANCE CARD IF APPLICABLE.

Medicaid/ SCHIP **Private DENTAL Insurance** (please provide copy of card) **None**

Medicaid Number/ Policy Number _____

Dental Ins. Name: _____ policy #_____ group # _____

Dental Ins. Address: _____ Ins. Phone # _____

Employer Name: _____

Treatment Consent and Agreement

I, _____, as a legally responsible guardian of _____
(print parent/legal guardian name) (print child's name)
give my consent for the dental services I have authorized below. I understand there may be risks involved with dental treatment. Please note that preventive dental hygiene services alone, provided outside of a regular dental office, should not replace regular dental exams by a dentist. Each item needs to be answered in order to receive dental care.

Yes	No	
		Preventive Services: screening by a hygienist, teeth cleaning, oral hygiene instruction, sealants, fluoride treatment.
		Dentist Exam (including dental x-rays)
		Restorative Services: fillings, stainless steel crowns, pulpotomy. Local anesthetic may be used for these procedures.
		Extractions: removal of primary (baby) or permanent teeth that cannot be restored through other treatments. Local anesthetic may be used for these procedures.
		The use of nitrous oxide (laughing gas) may be used as deemed necessary.
		I have been offered and/or read a copy of the Delta Dental's HIPAA Notice of Privacy Practices.

Parent/Legal Guardian signature _____ Date _____