Dental Eligibility and Medical History Form

Please use ink! 

Medical alert_____
PATIENT NUMBER_____

WELCOME

We are pleased to welcome you to Georgia Public Health. Please take a few minutes to fill out this form as completely as you can. If you have questions, we will be glad to help you. We look forward to working with you in maintaining your dental health.

Patient's Name: _____
Last First Middle
Address: _____
Street City Zip County
Home #(___)_____ **Cell #(___)**_____

SS#_____ **Birth Date:** _____/_____/_____ **Age:**_____ **Sex: M**_____**F**_____ **Race**_____

Fat.her's/Guardian Name:_____ **Cell Phone:(___)**_____

Employer: _____

Mother's/Guardian's Names: _____**Cell Phone :(___)** _____

Employer: _____

Emergency ContactPerson:_____**Phone:**_____

Medicaid Eligible? Yes_____ **No**_____ **Medicaid Number**____ ____ ____ ____ ____ ____ _____ _____ ____

Other Dental Insurance? Yes_____ **No**_____ **Company Name**_____

Policy Number: _____ **Group Number:** _____
Family Income:Weekly$**_____**Monthly$_____**Yearly$**_____

Total earnings of all family members before deductions, including welfare payments, wages of all working members, pensions, social security, unemployment compensations, child support payments, and all other income. If any special hardship conditions exist, explain: _____
_____
_____

Total Number In Family:_____ ***Include children and adults.***

Does patient attend school? Yes_____ **No**_____ **Name of School:**_____

Patients under 18 years of age must have the medical history and consent signed *in ink* by a parent or legal guardian before treatment begins.

OVER

PATIENT HISTORY CONFIDENTIAL

Please use ink! *Please circle yes or no.*

DOES PATIENT NOW HAVE (OR HAS PATIENT EVER HAD):

HEART TROUBLE?..... YES NO
HIGH BLOOD PRESSURE?..... YES NO
RHEUMATIC FEVER?..... YES NO
TUBERCULOSIS?..... YES NO
DIABETES?..... YES NO
KIDNEY DISEASE?..... YES NO
LIVER DISEASE?..... YES NO
HEPATITIS?..... YES NO
THYROID DISEASE?..... YES NO
EPILEPSY?..... YES NO
CANCER OR TUMORS?..... YES NO
PSYCHIATRIC PROBLEMS?..... YES NO
PROLONGED BLEEDING..... YES NO
BLOOD DISEASE? (ANEMIA)..... YES NO
HIV OR AIDS?..... YES NO
S.T.D.?..... YES NO
OTHER ALLERGIES/ (EXPLAIN)_____ YES NO
_____
ALLERGIES TO MEDICINE? (EXPLAIN)_____ YES NO
_____
ASTHMA?..... YES NO
HAS PATIENT EVER BEEN TO THE DENTIST?..... YES NO
OTHER SEVERE ILLNESSES? HOSPITALIZATION?..... YES NO
(EXPLAIN)_____
IS PATIENT UNDER THE CARE OF A PHYSICIAN?..... YES NO
(EXPLAIN)_____
IS PATIENT TAKING ANY MEDICATION? (LIST ALL)..... YES NO
PRESCRIPTIONS?_____ YES NO
OVER THE COUNTER?_____ YES NO
IS PATIENT PREGNANT? If yes, when is due date:_____ YES NO

Consent

I consent to general dental treatment for myself/minor child which in the judgement of the dentist is necessary for oral health. This treatment may include but is not limited to the following: restoration of teeth, x-rays, administration of drugs/local anesthetics, root canals, periodontal treatment, prosthetics, oral surgery and other specialty treatments deemed necessary. I approve the relaese of my records to my insurance/Medicaid or other dentists as deemed necessary by the dentist. I authorize you to verify employment, financial or medical history, and other related matters as ,ay be necessary to determine eligibility. I authorize the dentist to file claims and rceive as many years as my child is eligible, by the program policy, for this service. This permission can be revoked only by written notification to Dental Program Administrator, County Health Department.

I further verify that the above medical history is true and accurate to the best of my knowledge.

DATE_____ Signature_____

Check One: Parent ( ) LEGAL GUARDIAN ( )

Dentist is not permitted to begin treatment without this signed permission from parent or guardian

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Date_____ Signature_____

History Verified: Dentist Name

Date_____ Signature_____

History Verified: Dentist Name

Date_____ Signature_____

History Verified: Dentist Name