COBB & DOUGLAS PUBLIC HEALTH

Dental Eligibility and Medical History Form

Medical Alert: _____

Patient Number: _____

We are pleased to welcome you to Cobb & Douglas 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 Name: _____ _____ _____
Last Name First Name Middle Name

Address: _____ _____ _____ _____
Street City Zip Code County

Home Phone: _____ SS Number: _____ Age: _____

Birth Date: _____ Sex: ☐ Male ☐ Female Race: _____

Father's/ Guardian Name: _____ SS Number: _____

Employer: _____ Work Phone: _____

Mother's/ Guardian Name: _____ SS Number: _____

Employer: _____ Work Phone: _____

Emergency Contact Person: _____ Phone: _____

Medicaid Eligible?..... ☐ Yes ☐ No Medicaid Number: _____

Other Dental Insurance?..... ☐ Yes ☐ No Company Name: _____

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 (*Adults and Children*): _____

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.
Please complete the reverse side.

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PATIENT HISTORY CONFIDENTIAL

COBB & DOUGLAS PUBLIC HEALTH

Does Patient Now Have (Or has Patient Ever Had):

Heart Trouble	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Cancer or Tumors	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	Psychiatric Problems	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	Prolonged Bleeding	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Blood Disease (Anemia)	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No	Sickle Cell (Disease or Trait)	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No	HIV or AIDS	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	STD	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No			

Allergies to medicine? ☐ Yes ☐ No

Explain: _____

Other Allergies? ☐ Yes ☐ No

Explain: _____

Asthma? ☐ Yes ☐ No

Has this patient ever been to the dentist? ☐ Yes ☐ No

Other severe illnesses? Hospitalizations? ☐ Yes ☐ No

Explain: _____

Is patient under the care of a physician? ☐ Yes ☐ No

Explain: _____

Is patient taking an medications? ☐ Yes ☐ No

Prescriptions? ☐ Yes ☐ No

Over the Counter? ☐ Yes ☐ No

List All: _____

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 extracting of teeth, x-rays, administration of drugs/local anesthetics, root canals, periodontal treatments, prosthetics, oral surgery and other specialty treatments deemed necessary. I approve the release of my medical 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 may be necessary to determine eligibility. I authorize the dentist to file claims and receive reimbursement directly from my insurance/ Medicaid. I understand that this request for dental treatment is valid for 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, Cobb & Douglas Public Health. I further verify that the above medical history is true and accurate to the best of my knowledge.

Signature: _____ Date: _____

I have reviewed the above medical history and there has been no changes.

History Verified:

Dentist Name: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____