Dental Eligibility and Medical History Form

Please use ink!

Medical Alert _____

PATIENT NUMBER: _____

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 Phone: (____) _____ SSN#: _____
Area Code

Birth Date: ____/____/____ Age: _____ Sex: M____ F____ Race: _____

****

Father's /Guardian Name: _____ SSN#: _____

Employer: _____ Work Phone: _____

Mother's/ Guardian Name: _____ SSN#: _____

Employer: _____ Work Phone: _____

Emergency Contact Person: _____ 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.

****PLEASE COMPLETE AND SIGN BACK OF FORM****

over ↓

PATIENT HISTORY CONFIDENTIAL

Please use ink!

Please check the appropriate box

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

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 treatment, prosthetics, oral surgery and other specialty treatments deemed necessary. I approve the release 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 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, 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

DATE_____ SIGNATURE_____ History Verified : Dentist Name

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DATE_____ SIGNATURE_____ History Verified : Dentist Name

DATE_____ SIGNATURE_____

Patient Information

Today's Date _____

Name: _____ Birthdate: _____ Age: _____

Address: _____ Phone: _____

City _____ Zip _____ Social Security # _____

Parent or Guardian if minor _____

MEDICAID: Yes( ) No ( ) MEDICAID # _____

Insurance: Yes ( ) No ( ) Name: _____

Race: White___ Black ___ Asian ___ Indian ___ Hispanic___ Multi Racial ___

Sex: Male ___ Female ___ Number in family: ___ Monthly income (before taxes) _____

First visit ___ Return visit ___ Last visit _____
Year

Allergies: _____

Please check the type of Services you are requesting:

General Services
(walk-in services)
( ) Immunizations
( ) Head lice check
( ) TB skin test
( ) BP check
( ) Hearing, vision, dental
( ) Parasite tests
( ) Disability Screening
( ) School certificate
( ) Day care certificate
( ) Premarital Blood work

STD Services
Appointment Yes( ) No( )
( ) Routine check-up
for problem
( ) Blood work only
( ) HIV testing
( ) HIV results
( ) Other _____

Child Health
( ) Health check appointment
( ) CMS application
( ) Lead screen re-check

Cancer Screening
( ) Mammogram certificate
( ) Breast exam
( ) Pap smear
( ) Follow-up
( ) Colpo clinic

Family Planning
( ) Pregnancy test
( ) Physical
( ) Birth control refill
( ) Vaginitis check
( ) Other _____
( ) Lab work
( ) Medication pick-up

TB Services
First visit _____
( ) Lab work
( ) Medication pick-up
( ) Chest x-ray clinic
( ) Follow-up
( ) Other _____

Other Services
( ) _____
( ) _____
( ) _____

WIC
( ) Voucher pick-up
( ) Certification
( ) Re-certification

Prenatal Clinic
( ) Medicaid application
( ) Follow-up