Dental Consent and Medical History Form

Visiting Dental Hygiene Associates

Name: _____

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

Address: _____
(Street) (City/town) (State) (Zip Code

Phone:_____Email: _____

Adult/Long Term Care Facility _____

Please tell us *your* race:
D American Indian/Alaskan Native D Asian D Black/African American D Hispanic/Latino D White D Other

Health Information:
1. Are you taking any medication now? D YES D 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?
D YES D NO

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

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

4. Do you have any other health conditions? D YES D NO
If yes**,** please list._____

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

D Penicillin D Antibiotics D Anesthetics D Colophonium D Aspirin D Foods D Latex D Resins D Other: _____
6. Do you have a dentist? D YES D 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?
D Daily tooth brushing D Daily flossing D Inter-dental stimulators D Water jet device

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

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

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

D Blue Cross/Shield D Delta Dental D 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_____/_____/_____

Group/Policy #_____

Employer Name_____

I understand that the dental provider, Visiting Dental Hygiene Associates, 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**