

## 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:

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

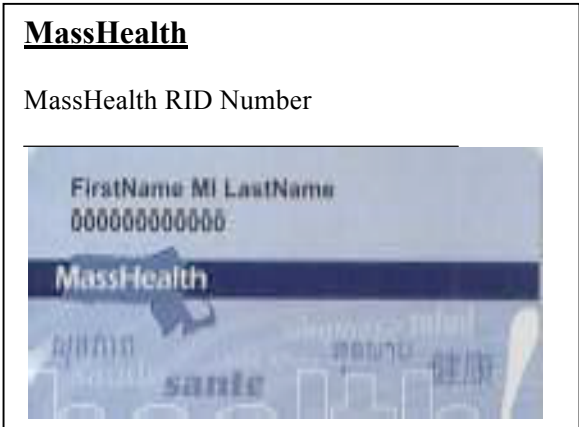
Name of dentist and office location: \_\_\_\_\_

When did you last see your dentist? \_\_\_\_\_

7. What do you do to take care of your teeth and gums?  
 Daily tooth brushing  Daily flossing  Inter-dental stimulators  Water jet device
8. Do you have any pain in your mouth today?  YES  NO
9. Do you have **DENTAL INSURANCE**?  YES  NO

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

Blue Cross/Shield  Delta Dental  Mass Health/Medicaid Other \_\_\_\_\_



**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**