Pender County Health Department
Mobile Dental Clinic

803 S. Walker Street, Burgaw, NC 28425
910-471-3250

PATIENT INFORMATION

LAST NAME:_____ FIRST NAME:_____ MI:____

MAILING ADDRESS:_____

CITY_____ STATE_____ ZIP CODE_____

DATE OF BIRTH:_____

SOCIAL SECURITY #:_____

CELL PHONE #:_____ or HOME PHONE #:_____

EMERGENCY CONTACT:_____ PHONE #:_____

EMPLOYER:_____ PHONE #:_____

PAYMENT INFORMATION

DO YOU HAVE MEDICAID? YES_____ NO_____ MEDICAID #:_____

INSURANCE:

DO YOU HAVE DENTAL INSURANCE? YES_____ NO_____
IF YES, PLEASE PROVIDE THE FOLLOWING INFORMATION:

POLICY HOLDER'S NAME:_____ SOCIAL SECURITY #:_____

INSURANCE CO. NAME:_____ SUBSCRIBER #:_____

GROUP PLAN #:_____ INSURANCE PHONE #:_____

EMPLOYER:_____

IF POSSIBLE, PLEASE BRING A COPY OF YOUR INSURANCE CARD, FRONT AND BACK. THANK YOU

PRIVATE PAY:

IF YOU DO NOT HAVE INSURANCE AND WANT TO APPLY FOR A DISCOUNT PLEASE PROVIDE THE FOLLOWING INFORMATION:

PROOF OF INCOME: MOST RECENT PAYSTUB OR LASTEST TAX RETURN FOR EVERYONE WORKING IN THE HOME.

FAMILY MEMBERS LIVING IN THE HOME: # OF ADULTS:_____ # OF CHILDREN:_____

TOTAL MONTHLY HOUSEHOLD INCOME $_____ EMPLOYER:_____

DO YOU RECEIVE UNEMPLOYMENT? YES_____ NO_____ AMOUNT: $_____

DO YOU RECEIVE DISABILITY? YES_____ NO_____ AMOUNT: $_____

DO YOU HAVE ANY OTHER FORM OF INCOME? YES_____ NO _____ AMOUNT: $_____

If Yes Please Explain:_____

*IF NO PROOF OF INCOME, YOU WILL BE CHARGED THE FULL AMOUNT.

DENTAL HISTORY

WHAT IS THE REASON FOR YOUR VISIT TODAY?_____

_____

DATE OF LAST DENTAL VISIT:_____

WERE X-RAYS TAKEN? YES_____ NO_____

HAVE YOU EVER HAD A BAD EXPERIENCE AT THE DENTIST? YES_____ NO_____

HOW OFTEN DO YOU BRUSH YOUR TEETH: _____

HOW OFTEN DO YOU FLOSS:_____

DO WEAR DENTURES OR PARTIALS? YES_____ NO_____

DO YOU HAVE ANY DENTAL PROBLEMS NOW? YES_____ NO_____

If Yes, Please Explain:_____

_____

HISTORY OF (Check all the apply)

___ BLEEDING GUMS **___ NAIL BITING HABITS** **___CAVITIES** **___ BAD BREATH**

___ PAIN IN TEETH **___ SNORING** **___ GRINDING TEETH**

___ COLD SORES/CANKER SORES

CONSENT

I give consent to receive dental treatment provided by Dr. Kathy Barnes, Pender County Health Department Mobile Dental Clinic.

After dental treatment is completed I agree that Dr. Kathy Barnes may file claims for dental care with the insurance company or other payer information that I have provided.

Signature of Patient (or Representative): _____ **Date:** _____

HIPPA

I have been provided with a copy of the Pender County Health Department Mobile Dental Clinic's HIPPA PRIVACY POLICY.

Signature of Patient (or Representative): _____ **Date:** _____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No _____
Are you on a special diet? Yes No
Do you use tobacco? Yes No
Do you use controlled substances? Yes No

Women: Are you
Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs

Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problem	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
						Yellow Jaundice	Yes No

Have you ever had any serious illness not listed above? Yes No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____