

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: _____ EMAIL: _____

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 _____