DELTA DENTAL

Delta Dental Mobile Program
Patient Information Form

Please fill out this form completely. If you have questions, please ask a Delta Dental staff member. Thank You!

Patient's Legal Name _____ Birth Date (mm/dd/yyyy) _____

School Attending _____ Grade _____ Age _____ Sex ☐ M ☐ F

Ethnicity: ☐ *White* ☐ *Black or African American* ☐ *Asian* ☐ *American Indian* ☐ *Hispanic/Latino* ☐ *Other*

Home Address _____
Mailing Address City State Zip

Phone Numbers: Home (_____) _____ Work (_____) _____

Cell (_____) _____

Parent/Guardian Name _____ Relation to patient _____

Emergency Contact: Person to contact in case of an emergency

Name _____ Relation to patient _____ Phone (____) _____

Income: Which of these best represents your annual household income?

☐ *Less than $10,000* ☐ *$10,000-20,000* ☐ *$20,000-30,000* ☐ *More than $30,000*

Household Size: How many children age 21 or younger live in your household? _____

Dental History (Note: Dental visits should start at first tooth.)	Yes	No	
Is this the patient's first dental visit? Past or current dentist name_____	☐	☐	If no, how long has it been? (√) ☐ less than 2 years ☐ more than 2 years
Has the patient visited the ER/hospital for dental pain in the last year?	☐	☐	If "yes", how many times?
Has dental pain caused you or your child to miss school and/or work in the last year?	☐	☐	If "yes", ☐ school ☐ work ☐ both How many times?

Medical History	Yes	No	Please Explain "yes" Answers
Patient's current physician _____ Date of last medical exam (mm/yy) _____			
Does the patient have a current medical condition?	☐	☐	
Is the patient taking any medications?	☐	☐	
Has the patient ever been hospitalized or had surgery?	☐	☐	
Does the patient have any allergies?	☐	☐	
Does the patient have any special needs that would require special arrangements for dental care? i.e. autism	☐	☐	
Is patient pregnant?	☐	☐	

Has the patient had a history of or had difficulty with the following? Check any that apply (√)

☐ AIDS / HIV	☐ Cerebral Palsy	☐ Fainting	☐ Liver disease
☐ Anemia	☐ Diabetes	☐ Heart problems	☐ Mono
☐ Asthma	☐ Epilepsy/ seizures	☐ Hepatitis	☐ Rheumatic fever
☐ Birth defects	☐ Excessive bleeding	☐ Kidney disease	☐ Tuberculosis
☐ Cancer	☐ Other _____		

Please explain your answers: _____

Reason for Visit: Check any that apply (√)

☐ First examination ☐ Couldn't afford dental care ☐ Couldn't get appointment anywhere else

☐ Toothache/mouth pain/face swelling ☐ Other (specify)_____

Patient Behavior	Yes	No	
Does the patient brush daily?	☐	☐	
Does the patient drink soda pop or other sugar sweetened drinks daily (Kool-aid, fruit drink, Gatorade, sport drinks)?	☐	☐	
Is the patient using tobacco products (cigarettes, chewing tobacco, smokeless tobacco)?	☐	☐	
Does anyone in the household use tobacco products (cigarettes, chewing tobacco, smokeless tobacco)?	☐	☐	

Insurance: Please check any that apply. If Medicaid or private dental insurance, please indicate Medicaid number or policy number in the space provided.

MUST PROVIDE A COPY OF YOUR DENTAL INSURANCE CARD IF APPLICABLE.

☐ Medicaid/ SCHIP ☐ Private DENTAL Insurance (please provide copy of card) ☐ None

Medicaid Number/ Policy Number _____

Dental Ins. Name: _____ policy #_____ group # _____

Dental Ins. Address: _____ Ins. Phone # _____

Employer Name: _____

Treatment Consent and Agreement

I, _____, as a legally responsible guardian of _____
(print parent/legal guardian name) (print child's name)
give my consent for the dental services I have authorized below. I understand there may be risks involved with dental treatment. Please note that preventive dental hygiene services alone, provided outside of a regular dental office, should not replace regular dental exams by a dentist. Each item needs to be answered in order to receive dental care.

Yes	No	
☐	☐	Preventive Services: screening by a hygienist, teeth cleaning, oral hygiene instruction, sealants, fluoride treatment.
☐	☐	Dentist Exam (including dental x-rays)
☐	☐	Restorative Services: fillings, stainless steel crowns, pulpotomy. Local anesthetic may be used for these procedures.
☐	☐	Extractions: removal of primary (baby) or permanent teeth that cannot be restored through other treatments. Local anesthetic may be used for these procedures.
☐	☐	The use of nitrous oxide (laughing gas) may be used as deemed necessary.
☐	☐	I have been offered and/or read a copy of the Delta Dental's HIPAA Notice of Privacy Practices.

➡ Parent/Legal Guardian signature _____ Date _____