DENTAL PATIENT MEDICAL HISTORY

School Name: **Grant Elementary** Year: **2014-2015**

PATIENT DEMOGRAPHICS Teacher's Name _____ Grade _____

Name of Child (last, first, middle) _____ **Date of Birth** ___/___/___

Street Address _____ Country _____ **Email Address:** _____

City: _____ State _____ Zip _____ Gender ___ Male ___ Female

Ethnicity _____ Language _____ **Preferred Pharmacy** _____

Home Phone Number _____ Email Address:_____ _____

Emergency Contact Person _____ Emergency Contacts Phone _____

Parent/Guardian Name _____ Parent/Guardian Date of Birth ___/___/___

Parent's Street Address _____ Check here if same as child's above _____

City _____ State _____ Zip _____ Phone Number _____

INSURANCE INFORMATION If a parent/guardian insures child please include ALL of the subscribers info for billing purposes.

Does your child receive Medicaid benefits? ____Yes **Medicaid ID #** _____ ____No

Do you have any other dental insurance? ____Yes Name of Insurance _____ ____No

If yes - Name of Insured _____ Relationship to patient _____

Date of Birth _____ Social Security # _____ (Manditory for billing)

Name of Employer _____ Contract/ ID # _____ Work Phone _____

Insurance Company _____ Group # _____ Insurance Phone # _____

Please circle any of the following that your child had in the past or has presently:

Heart Disease/Murmur	Unusual Bleeding	Asthma	HIV/AIDS	Autism
Artificial Heart Valve	Cancer	Diabetes	Epilepsy or Seizures	Other: Please use back to explain

PLEASE CIRCLE YES OR NO FOR THE FOLLOWING QUESTIONS. (IF IN DOUBT, CIRCLE YES)
IF YES, PLEASE GIVE DETAILS. FEEL FREE TO CONTINUE COMMENTS ON BACK IF NECESSARY.

1.	Has your child been under the care of a physician during the past year?	YES	NO
2.	Is your child presently taking any medicine or drugs? (please list)	YES	NO
3.	Is your child allergic to any medicine or material? (please list)	YES	NO
4.	Has your child ever experienced any complication following dental treatment?	YES	NO
5.	Does your child have any diseases or conditions not listed above? (please list)	YES	NO
6.	Does your child currently receive a fluoride supplement?	YES	NO

If the child has a dentist, you may wish to continue dental services with that provider. To avoid dental service or benefit duplication, please inform your dentist which services were performed at school.

I am a custodial parent or legal guardian of the child named above. I authorize and consent to this child receiving dental care **twice** during the school year at 6 month intervals. I authorize Family Health Care to bill for the services provided and collect payment from any insurance or third party payer that covers the services provided. I accept financial responsibility for any outstanding charges for all professional services provided. I acknowledge being informed of Family Health Care's Notice of Privacy (located on the back side of the letter).

SIGNATURE OF PARENT/GUARDIAN: _____ DATE _____

PRINTED NAME: _____ DATE _____

RELATIONSHIP TO CHILD: _____

DENTIST'S / HYGIENIST SIGNATURE _____ DATE _____

Due:_____ Not Due:_____ Ins:_____ Updated 6/10/14 **Form #842** 10-14-14