VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment

Part I Patient Information

Patient Name: _____ Date of Birth: _____ Sex: _____ Race: _____

Address: _____ City: _____ Zip: _____

Telephone/Home: _____ Work/Emergency: _____

I.D. Number: _____ Social Security Number: _____

Parent/Guardian/Spouse: _____

Head of Household: _____ Date of Birth: _____

Does the Patient have *Medicaid*? Yes: ___ No: __ _____
(Policy Number)

Other Insurance/*Medicaid* HMO? _____ _____
(Company) *(Policy Number)*

Has the Patient completed the eligibility process for health department services? Yes: ___ No: ___

Has the Patient ever been to this dental clinic? Yes: ___ No: ___ Does the patient receive a "free lunch"? Yes: ___ No: ___

When did the Patient last visit a dentist? _____ _____
(Date) *(Dentist/Location)*

What dental work was done (i.e. exam, fillings, extractions, other)? _____

Who is the Patient's physician? _____ _____
(Physician's Name) *(Address)*

Last Office Visit: _____ Last Physical Examination: _____
(Date) *(Date)*

Part II Medical History

Please Circle **Yes** or **No**

Is the Patient in good health? . . . . . Yes No

If not, explain: _____

Is the Patient taking any medicine, drugs, herbs or non-prescription supplements? . . . . . Yes No

Please list all: _____

_____

Does the Patient use:

Alcohol . . . . . Yes No

Tobacco . . . . . Yes No

Recreational Drugs . . . . . Yes No

Is the Patient allergic to penicillin? . . . . . Yes No

Does the Patient have any other allergies: . . . . . Yes No

Medicines (list) _____

Latex or Rubber . . . . . Yes No

Dental Anesthetic (numbing) . . . . . Yes No

Any other allergies _____

Is the Patient pregnant? . . . . . Yes No

Is the Patient breast-feeding? . . . . . Yes No

Has the Patient had:

Cancer . . . . . Yes No

Leukemia . . . . . Yes No

Tumor . . . . . Yes No

_____ _____ _____
(Date) *(Physician/Oncologist)* *(Surgery/Chemotherapy/Radiation)*

Does the Patient have:

Asthma . . . . . Yes No

Other Respiratory Problems . . . . . Yes No

(continued)

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(continued)

Does the Patient use an inhaler or medications for breathing? . . . . . Yes No

Does the Patient have *HIV* or *AIDS*? . . . . . Yes No

Has the Patient ever had any of the following conditions:

Heart Disease . . . . . Yes No
Heart Valve Replacement . . . . . Yes No
Stroke . . . . . Yes No
Heart Murmur . . . . . Yes No
High Blood Pressure . . . . . Yes No
Rheumatic Fever . . . . . Yes No
Diabetes . . . . . Yes No
Sickle Cell Anemia . . . . . Yes No
Bleeding Disorders . . . . . Yes No
Anemia . . . . . Yes No
Hepatitis . . . . . Yes No
Tuberculosis . . . . . Yes No
Goiter/Thyroid/Glandular Conditions . . . . . Yes No
Kidney Problems . . . . . Yes No
Dialysis/Transplant . . . . . Yes No
Epilepsy/Seizures . . . . . Yes No
Arthritis/Joint Pain . . . . . Yes No
Pain in Jaws/TMJ . . . . . Yes No
Artificial Joint . . . . . Yes No
Growth/Development Conditions . . . . . Yes No
Birth Defects/Premature Birth . . . . . Yes No
Developmentally Delayed . . . . . Yes No
Hyperactivity/ADD/ADHD . . . . . Yes No
Autism . . . . . Yes No
Cerebral Palsy . . . . . Yes No
Hearing/Speech Conditions . . . . . Yes No
Psychiatric/Psychological Conditions . . . . . Yes No
Sexually Transmitted Disease . . . . . Yes No
Drug Addiction . . . . . Yes No

Is there a history of any of these problems in the past? . . . . . Yes No

Is there anything else we should know? _____

_____

Medical History Update

Date					
Signature					

Part III Consent

The information given in Parts I, II and III of this form is accurate to the best of my knowledge or belief.

Informed Consent

Problems arising from dental treatment are extremely rare but may include pain or infection. Not treating dental disease may have the same result. If a tooth cavity is very deep and the nerve and blood supply are affected, or if bone loss or swelling are present, the removal of the nerve or the tooth with local anesthesia, may be necessary. Please feel free to discuss any concerns you have with the Public Health Dentist.

I authorize the Public Health Dentist to perform on my child or myself a dental examination and treatment such as cleaning, treatment of gum disease, fluoride and sealant applications, fillings with local anesthesia and other treatments as deemed necessary by the dentist.

Date: _____ Signature: _____
(Patient/Parent/Guardian)

Notice of Deemed Consent for HIV, HBV and HCV Testing

If one of our health care professionals, workers or employees should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with Human Immunodeficiency Virus (HIV, the AIDS Virus) and for the presence of the Hepatitis B and Hepatitis C Viruses. A physician or other health care provider will tell you and that person the result of the test and provide counseling, if necessary.

If you should be directly exposed to blood or body fluids of one of our health care professionals, workers or employees in a way that may transmit disease, that person's blood will be tested for infection with Human Immunodeficiency Virus (HIV, the AIDS Virus) and for the presence of the Hepatitis B and Hepatitis C Viruses. A physician or other health care provider will tell you and that person the result of the test and provide counseling, if necessary.

Date: _____ Signature: _____
(Patient/Parent/Guardian)