CHILD PATIENT INFORMATION

Patient Name ______________________________ Birthdate ______________ Sex: M _____ F______

Address ____________________ City __________________ State _________ Zip __________ Phone ________

Social Security # ______________________________ Marital Status: ____________ Race: ____________
(for statistical purposes only)

Employer Name ______________________ Address __________________________ Phone __________

PARENT / GUARDIAN INFORMATION (Please Circle One)

Mother's/Guardian's Name ______________________________ Birthdate ____________ SS# ______________

Mother's/Guardian's Address ____ Phone ________
City State Zip

Mother's/Guardian's Employer ____ Phone _________

Work Address ____
City State Zip

Father's/Guardian's Name ______________________________ Birthdate ____________ SS# ______________

Father's/Guardian's Address ____ Phone ________
City State Zip

Father's/Guardian's Employer ____ Phone _________

Work Address ____
City State Zip

EMERGENCY CONTACT

Name ____________________________________ Phone __________________
(other than Spouse/Parent/Guardian)

PATIENT INSURANCE COVERAGE

Primary Insurance ____________________________ Group/ID # ______________________________

Primary Insurance ____________________________ Group/ID # ______________________________

DOES PATIENT HAVE MEDICAID OR MEDICARE COVERAGE? Yes_____ No_____ (If yes, please give # below)

Medicaid # ___________________________________ Medicare # ______________________________

IS PATIENT SELF-PAY? Yes______ No_______ (A sliding fee scale is required for all self-pay patients)

I hereby authorize the release of any medical/dental information necessary for the processing of insurance. I also authorize insurance benefits to be paid directly to Community Health Services. I understand that if my insurance does not pay, I am responsible for payment of services provided.

Signature ____ Date ____________________

Revised 03/08 Provider #: _________

CHS

COMMUNITY HEALTH SERVICES

DENTAL
MEDICATION/DRUG LIST

Name ________________________________ Date of Birth ________________

Medications your dentist uses in routine dental treatment may interact with both prescription and **street/illicit** drugs.

These reactions may result in **SEVERE INTERACTIONS**. It is **extremely** important that you inform your dentist of **any drug** you currently use or may have taken so that this may be considered in your dental treatment planning.

This information will be held in **strict confidence** and will be used only for safe, appropriate dental care.

Medication/Drug	Purpose

Rev 03/08

CHS

COMMUNITY HEALTH SERVICES
DENTAL CLINIC

MEDICAL HISTORY

Patient Name: ____ Date: ____________________
Last First M.I.

Address: ____
Number and Street City State Zip

Home Phone: ___________________________ Work Phone: ___________________________

Date of Birth: ______________________ Sex: M F Height: _________________ Weight: ____________

If you are completing this form for another person, what is your relationship to that person? _________________

Patient's Family Doctor: ____

Approximate Date of Last Medical Visit: ____________ Approximate Date of Last Dental Visit: _____________

PLEASE ANSWER EACH QUESTION **CIRCLE**

1. Have you been under the care of a physician during the past 2 years? Yes No
2. Are you allergic to penicillin or any drugs or medicine? Yes No
   Please list: ____
3. Have you ever had any excessive bleeding requiring special treatment? Yes No
4. Circle any of the following which you have or have had:

Heart Disease	Tuberculosis (TB)	Anemia	Epilepsy	HIV
Cancer, Tumor	Rheumatic/Scarlet Fever	Arthritis	Asthma	Venereal Disease
Cardiac Pacemaker	Psychiatric Treatment	Hepatitis	Sinus Trouble	(VD) Type:
Heart Murmur	Cancer Treatment	Cough	Jaundice	_____________
Diabetes	High Blood Pressure	Stroke		

5. Have you had any other medical conditions of which we should be aware? Yes No
   Please list: ____
6. (Women) Are you pregnant now? Yes No
7. (Women) Are you currently nursing? Yes No
8. Have you ever been diagnosed or treated for chemical dependency or alcoholism? Yes No
   If yes, when was your last usage and what was it? ____________________________________
9. Have you taken any kind of medicine or drugs during the past year? Yes No

Please list all medications you are currently taking on the medication sheet.

Signature: ____ Date _________________

Signature, DDS: ____ Date _________________

6/2008