# SAMPLE Dental Consent and Medical History Form for an Adult

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# (Name of Public Health Dental Hygienist and/or Program)

# 

# Please print in ink

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_ \_/\_ \_ /\_ \_ \_ \_ Male Female Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Street) (City/town) (State) (Zip Code

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number \_\_ \_\_ \_\_ -\_\_ \_\_- \_\_ \_\_ \_\_ \_\_ Adult/Long Term Care Facility \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please tell us *your* race:

American Indian/Alaskan Native Asian Black/African American Hispanic/Latino White Other

**Health Information:**

1. Are you taking any medication now? YES NO

***If yes***, please list both prescribed and over the counter medications that you take in the space below:

|  |  |
| --- | --- |
|  |  |
|  |  |
|  |  |
|  |  |

2. Has a dentist or physician ever told you that you need to take antibiotics (penicillin) before having dental treatment? YES NO

3. Please check any illnesses or conditions you have EVER had:

|  |  |  |
| --- | --- | --- |
| Alcohol abuse | Drug Abuse | Rheumatic Fever |
| Allergies to Medicine(s) | Epilepsy | Shingles |
| Anemia or blood problems | Glaucoma | Sinus problems |
| Any Heart Ailments | Heart Murmur | Stroke |
| Arthritis | Hepatitis A, B, C | Thyroid Problems |
| Artificial Joint | High Blood Pressure | Tuberculosis |
| Asthma | Immune system, HIV, AIDS, ARC | Ulcer or colitis |
| Cancer or Chemotherapy | Kidney problems | Use of tobacco, cigarettes, chew |
| Diabetes | Liver problems | Sexually Transmitted Disease |
|  | Psychiatric care/emotional problems |  |

4. Do you have any other health conditions? YES NO

***If yes*,** please list.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Do you have any allergies? ***If yes***, please check all that apply: YES NO

Penicillin Antibiotics Anesthetics Colophonium Aspirin Foods Latex Resins Other: \_\_\_\_\_\_\_\_\_\_

6. Do you have a dentist? YES NO

Name of dentist and office location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did you last see your dentist? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. What do you do to take care of your teeth and gums?

Daily tooth brushing Daily flossing Inter-dental stimulators Water jet device

8. Do you have any pain in your mouth today? YES NO

9. Do you have **DENTAL INSURANCE**? YES NO

***If you have dental insurance,*** please check which one and complete below:

Blue Cross/Shield Delta Dental Mass Health/Medicaid Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Delta Dental, CMSP, or Other Dental Insurance**

Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber ID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Date of Birth \_\_\_\_\_ /\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

Subscriber’s Social Security Number\_ \_ \_/\_ \_/\_ \_ \_ \_

Group/Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### MassHealth

MassHealth RID Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



I understand that the dental provider, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, may use my health information for treatment, payment and health care operations. I have been given a copy of the Dental Provider’s Notice of Privacy Practices.

I have read and understand the services that may be provided to me by this dental program and I consent to participate. I understand that I may continue to obtain dental care through any other provider. I understand that these services are not a substitute for an examination by a dentist. I understand that I should obtain a dental examination by a dentist within 90 days, if I have not had one, and if needed, this program will provide me with a list of dentists in my area.

I authorize the dental provider to consult with my medical provider(s) as may be appropriate to my health and the provision of dental care. If applicable, I authorize the dental program to provide a written summary of the examination and services provided to the official designee of my long term care facility or residential facility or institution.

If I have dental insurance, I authorize my insurance carrier to be billed for any services provided. I understand that this treatment may affect my future rights and benefits under my dental insurance. If I do not have dental insurance, I will pay the Dental Provider for all dental services that are charged to me.

**X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date**:\_\_\_/\_\_\_/\_\_\_ **Relationship to Patient**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Patient/Legal Representative Signature

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print Name Daytime Phone Number Cell Phone**