LINCOLN-LANCASTER COUNTY HEALTH DEPARTMENT DENTAL CLINIC

Child/Adolescent's Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Age _____ Date of Birth _____ Height _____ Weight _____ ❒ Male ❒ Female

Parents or Legal Guardian _____ School _____ Grade _____

Cell Phone _____ Child/Adolescent's Social Security # _____

Mother's Cell Phone _____ Mother's Place of Employment _____ Work Phone _____

Father's Cell Phone _____ Father's Place of Employment _____ Work Phone _____

Email Address _____

Person to contact in case of emergency? _____ Phone _____

CHIEF DENTAL COMPLAINT _____

MEDICAL HISTORY

	Yes	No
1) Has he/she been a patient in a hospital during the past two years?	❒	❒
2) Has he/she been under the care of a medical doctor during the past two years?	❒	❒
If yes, physician's name_____		
3) Has he/she had a positive blood or skin test for Tuberculosis?	❒	❒
If yes, has he/she had a chest x-ray since the positive test? Date _____ Results_____		
4) Does he/she have active Tuberculosis?	❒	❒
Been exposed to anyone with active Tuberculosis?	❒	❒
Persistent cough greater than 3 week duration?	❒	❒
Cough that produces blood?	❒	❒
5) Has he/she ever had any excessive bleeding requiring special treatment?	❒	❒
6) When he/she walks upstairs or takes a walk, does he/she ever have to stop because of pain in his/her chest, or shortness of breath, or because he/she is tired?	❒	❒
7) Has he/she had unexplained loss or gain of more than 10 pounds in the past year?	❒	❒
8) Does he/she ever wake up from sleep short of breath or sweating heavily?	❒	❒
9) Is he/she on a special diet? Doctor's order or self-imposed?	❒	❒
10) Has his/her medical doctor ever said he/she has cancer or a tumor?	❒	❒
11) To your knowledge, does he/she smoke or use smokeless tobacco products such as chewing tobacco?	❒	❒
If yes, how much per day? _____		
12) To your knowledge, does he/she drink alcohol?	❒	❒
If yes, how many drinks per week? _____		

	Yes	No
Low Blood Pressure	❒	❒
High Blood Pressure	❒	❒
Stroke	❒	❒
Infection In Heart	❒	❒
Heart Attack	❒	❒
Artificial Heart Valve	❒	❒
Heart Birth Defects	❒	❒
Easily Winded	❒	❒
Chest Pains/Angina	❒	❒
Cardiac Pacemaker	❒	❒
Swollen Ankles	❒	❒
Recent Weight Gain	❒	❒
Diabetes	❒	❒
Glaucoma	❒	❒
Frequently Tired	❒	❒
Recent Weight Loss	❒	❒
Anemia	❒	❒
Blood Disease	❒	❒
Hepatitis/Jaundice	❒	❒
Sexually Transmitted Disease	❒	❒
AIDS or HIV Infection	❒	❒

	Yes	No
Leukemia	❒	❒
Cancer or Tumor	❒	❒
Radiation Therapy	❒	❒
Chemotherapy	❒	❒
Respiratory Problems	❒	❒
Hay Fever/Allergies	❒	❒
Asthma	❒	❒
Emphysema	❒	❒
Liver Disease	❒	❒
Kidney Disease	❒	❒
Thyroid Problem	❒	❒
Arthritis	❒	❒
Joint Replacement or Implant	❒	❒
Stomach Troubles or Ulcers	❒	❒
Fainting/Seizures	❒	❒
Epilepsy/Convulsions	❒	❒
Mental Health Disorder	❒	❒

13) Does he/she have any disease(s), condition(s), or problems(s) not listed? ❒ ❒

Please list _____

_____

- OVER -

MEDICATIONS

Is he/she taking any of the following?	Yes	No
1) Antibiotics	❒	❒
2) Sulfa drugs	❒	❒
3) Anticoagulants (blood thinners)	❒	❒
4) Medicine for high blood pressure	❒	❒
5) Cortisone (steroids)	❒	❒
6) Tranquilizers	❒	❒
7) Antihistamines	❒	❒
8) Antidepressant/Antianxiety Medications	❒	❒
9) Aspirin (regular, ongoing basis)	❒	❒
10) Insulin, Orinase, or similar drug	❒	❒
11) Digitalis or other heart drug	❒	❒
12) Nitroglycerin	❒	❒
13) Chemotherapy	❒	❒
14) Alcohol/Drugs (chemically dependent)	❒	❒
15) Diet pills	❒	❒
16) Vitamin/herbal supplements	❒	❒
17) Other medications	❒	❒

Comments _____

ALLERGIES

Is he/she allergic to or had a reaction to any of the following?

	Yes	No
1) Local anesthetic (novocaine, etc.)	❒	❒
2) Antibiotics_____	❒	❒
3) Sulfa drugs	❒	❒
4) Latex	❒	❒
5) Barbituates, sedatives	❒	❒
6) Aspirin	❒	❒
7) Iodine	❒	❒
8) Codeine or other narcotics	❒	❒
9) Metals (rings, earrings, etc.)	❒	❒
10) Other allergies_____	❒	❒

DENTAL HISTORY

	Yes	No
1) Is he/she having dental pain?	❒	❒
2) Do you think he/she has gum problems?	❒	❒
3) Does he/she notice popping, clicking, soreness of the jaw or just in front of your ears?	❒	❒
4) Is he/she involved in any contact sports?	❒	❒
5) Does he/she brush daily?	❒	❒
6) Does he/she floss daily?	❒	❒
7) Has he/she ever had problems with local anesthetic?	❒	❒
8) Has he/she ever had any difficult extractions (tooth removal) in the past?	❒	❒
9) Has he/she ever had prolonged bleeding following extractions (tooth removal)?	❒	❒
10) Do you wear complete or partial dentures?	❒	❒

If so, how many years have you worn dentures? _____

How old are your present dentures? _____

11) When was his/her last dental visit? _____

12) What was done at his/her last dental visit? _____

_____

_____

_____

ADOLESCENT FEMALE

	Yes	No
1) Is she pregnant?	❒	❒
2) Is she nursing?	❒	❒
3) Does she have or has she had menstrual problems?	❒	❒
4) Is she taking birth control pills?	❒	❒

TREATMENT CONSENT

I certify that I have read and understand the above information. To the best of my knowledge, the above answers are true and correct. I understand that providing incorrect information can be dangerous to my child's health. If there is a change in my child's health, or if my child's medicines change, I will inform the dental staff at the next appointment without fail. I understand the nature of the clinical services to be rendered including the possible hazards and side effects that may be involved. I understand that alternative methods of treatment may be available and that while all the procedures are considered safe, there is risk of complications or unanticipated results and emergency indications that may prevent the intended beneficial result or require further treatment. I understand that dental services will be rendered by licensed dentists, licensed dental hygienists, or dental and dental hygiene students under the supervision of licensed dentists, and consent to such services. I authorize the Lincoln-Lancaster County Health Department to release any information including the diagnosis of the records of any treatment or examination rendered to my child during the period of such Dental care to third party payors and/or health practitioners.

Signature _____ Date _____