

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		Yes	No		Yes	No
1) Has he/she been a patient in a hospital during the past two years?	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>
2) Has he/she been under the care of a medical doctor during the past two years?	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Cancer or Tumor	<input type="checkbox"/>	<input type="checkbox"/>
If yes, physician's name _____			Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
3) Has he/she had a positive blood or skin test for Tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>	Infection In Heart	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
If yes, has he/she had a chest x-ray since the positive test?			Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>
Date _____ Results _____			Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever/Allergies	<input type="checkbox"/>	<input type="checkbox"/>
4) Does he/she have active Tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>	Heart Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Been exposed to anyone with active Tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough greater than 3 week duration?	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains/Angina	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cough that produces blood?	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
5) Has he/she ever had any excessive bleeding requiring special treatment?	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
7) Has he/she had unexplained loss or gain of more than 10 pounds in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement or Implant	<input type="checkbox"/>	<input type="checkbox"/>
8) Does he/she ever wake up from sleep short of breath or sweating heavily?	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles or Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
9) Is he/she on a special diet? Doctor's order or self-imposed?	<input type="checkbox"/>	<input type="checkbox"/>	Frequently Tired	<input type="checkbox"/>	<input type="checkbox"/>	Fainting/Seizures	<input type="checkbox"/>	<input type="checkbox"/>
10) Has his/her medical doctor ever said he/she has cancer or a tumor?	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
11) To your knowledge, does he/she smoke or use smokeless tobacco products such as chewing tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Disorder	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how much per day? _____			Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>			
12) To your knowledge, does he/she drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>			
If yes, how many drinks per week? _____			Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>			
			AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>			
			13) Does he/she have any disease(s), condition(s), or problems(s) not listed?				<input type="checkbox"/>	<input type="checkbox"/>
			Please list _____					

MEDICATIONS

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

Comments _____

ALLERGIES

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

- | | Yes | No |
|---------------------------------------|--------------------------|--------------------------|
| 1) Local anesthetic (novocaine, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Antibiotics _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Sulfa drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Latex | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) Barbituates, sedatives | <input type="checkbox"/> | <input type="checkbox"/> |
| 6) Aspirin | <input type="checkbox"/> | <input type="checkbox"/> |
| 7) Iodine | <input type="checkbox"/> | <input type="checkbox"/> |
| 8) Codeine or other narcotics | <input type="checkbox"/> | <input type="checkbox"/> |
| 9) Metals (rings, earrings, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 10) Other allergies _____ | <input type="checkbox"/> | <input type="checkbox"/> |

DENTAL HISTORY

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

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 _____