Loudoun County Health Department

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: _____

Parents/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,extrications, 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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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 II of this form is accurate to the best of my knowledge of belief.

Informal 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 of 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 Heath 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 Immune deficiency 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 heath care professionals, workers or employees in a way that may transmit disease, that person's blood will be tested for infection with Human Immune deficiency 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)