DELTA DENTAL

MOBILE PROGRAM

Patient Information and Permission Form

General information

Patient information

Legal name

Age ____ Birth date (mm/dd/yyyy) ___/___/____

Sex ☐ Male ☐ Female

School attending ____ Grade ____

Race
☐ White ☐ Asian ☐ Other
☐ Black or African American
☐ American Indian or Alaska Native
☐ Hawaiian or Other Pacific Islander
☐ Hispanic or Latino ☐ Not Hispanic or Latino

Parent/guardian information

Name

Relation to patient

Home (mailing) address

City ____ Zip ____

Home phone (____)____-____

Work phone (____)____-____

Cell phone (____)____-____
☐ Check here if you do not want to receive text messages.

Emergency contact information

Name

Relation to patient

Phone (____)____-____

Dental history

Dental visits should start at first tooth.

☐ Yes ☐ No Is this the patient's first dental visit?
If no, how long has it been?
☐ Less than 2 years ☐ More than 2 years

Past or current dentist's name

☐ Yes ☐ No Is the patient experiencing toothache/ mouth pain/face swelling?

☐ Yes ☐ No Has the patient visited the ER/hospital for dental pain in the last year?

☐ Yes ☐ No Has dental pain caused you or your child to miss school and/or work in the last year?
☐ School ☐ Work ☐ Both

Medical history

Patient's current physician

Date of last medical exam (mm/yy) ____/____

☐ Yes ☐ No Is the patient taking any medications?
If yes, please list ____

☐ Yes ☐ No Does the patient have any allergies?
If yes, please list ____

☐ Yes ☐ No Does the patient have any special needs that would require special arrangements for dental care? e.g. autism
If yes, please explain ____

☐ Yes ☐ No Is the patient pregnant?

Does the patient have, or have they had, a history of the following:

☐ ADHD
☐ AIDS / HIV
☐ Anemia
☐ Anxiety
☐ Asthma
☐ Birth defects
☐ Cancer
☐ Cerebral Palsy
☐ Diabetes
☐ Epilepsy/seizures
☐ Excessing bleeding
☐ Fainting
☐ Heart problems
☐ Hepatitis
☐ Kidney disease
☐ Liver disease
☐ Mono
☐ Rheumatic fever
☐ Tuberculosis
☐ Other ____

Please explain your answers: ____

Continue on back.

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Patient behavior

☐ Yes ☐ No Does the patient brush daily?

☐ Yes ☐ No Does the patient drink soda pop or other sugar-sweetened drinks (Kool-Aid, fruit drink, sports drink) daily?

☐ Yes ☐ No Is the patient using tobacco or vaping products?

☐ Yes ☐ No Does anyone in the household use tobacco or vaping products?

Household information

Annual household income

☐ Less than $10,000 ☐ $10,000-20,000

☐ $20,000-30,000 ☐ More than $30,000

How many children age 21 or younger live in your household?

____

Insurance

Please check any that apply.

☐ No dental insurance

☐ Medicaid

Medicaid number ______________________________

☐ Private DENTAL insurance (please provide copy of card)

____

Dental insurance name

____

Policy number

____

Group number

____

Dental insurance address

Insurance phone (__________)__________-__________

____

Employer name

IMPORTANT - Permission to provide treatment

We cannot treat your child if form is not signed.

I, ______________________________, as a legally responsible guardian of ______________________________

Print parent/legal guardian name Print child's name

give my permission for the dental services I have authorized below. Please note that preventive dental hygiene services alone, provided outside of a regular dental office, should not replace regular exams by a dentist. I have been offered and/or have read Delta Dental's HIPAA Notice of Privacy Practices available at southdakota.deltadental.com/privacy-and-policies/notice-of-privacy-practices/.

Each item needs to be answered in order to receive dental care.

☐ Yes ☐ No Preventive services: screening by a hygienist, teeth cleaning, oral hygiene instruction, sealants, fluoride treatment.

☐ Yes ☐ No Dentist exam (including dental x-rays)

☐ Yes ☐ No Restorative services: fillings, stainless steel crowns, pulpotomy. Local anesthetic may be used for these procedures.

☐ Yes ☐ No Silver diamine fluoride (decayed area of the tooth will be stained black permanently – please see attached for more information about this treatment)

☐ Yes ☐ No Extractions: removal of primary (baby) or permanent teeth that cannot be restored through other treatments. Local anesthetic may be used for these procedures.

☐ Yes ☐ No The use of nitrous oxide (laughing gas) may be used as deemed necessary.

______________________________ ______/______/______

Parent/legal guardian signature Date

V0621

Fill out front, too.