

PATIENT HEALTH RECORD

Today's Date _____

Patient's Name _____
Last First Middle

Address: _____ City _____ Zip _____

DOB _____ Age _____ Race _____ Sex _____

Father's Name _____ Cell# _____

Mother's Name _____ Cell# _____

Mother/Father DOB _____ Alternate Contact # _____

Family Email: _____

Reason for visit? _____ When was your last dental visit? _____

Yes No Have you ever had any serious problem associated with previous dental treatment?

If Yes explain: _____

Yes No Is there any condition you feel your dentist should know about before undertaking treatment?

Please describe _____

Yes No Do you clench or grind your jaws while sleeping or during the day?

Yes No Do your gums feel tender or swollen?

Yes No Do you smoke or use smokeless tobacco?

Yes No Do you have swelling in your jaw or neck?

Primary Care Doctor _____

I consent to general dental treatment for my minor child or myself, which in the judgment of the dentist is necessary for oral health. This treatment may include but is not limited to the following: restoration of teeth, extraction of teeth, x-rays, administration of drugs/local anesthetics, root canals, periodontal treatment, prosthetics, oral surgery, cleaning, exam, fluoride, sealants, and other specialty treatments deemed necessary. I approve the release of my records to my insurance/Medicaid or to other health professionals as deemed necessary by the dentist. I authorize employment, financial records or medical history, and other related matters as may be necessary to determine eligibility. I authorize the dentist to file claims and receive reimbursement directly from my insurance/Medicaid. I understand that this treatment request for dental treatment is valid for as many years as my child is eligible, by program policy, for this service. I have received the NOTICE OR PRIVACY POLICY FOR THE LAURENS COUNTY BOARD OF HEALTH. The South Central Health District Oral Health Program is a training facility for Central Georgia Technical College, Dental Hygiene Program. A dental hygiene student may be participating in and providing care to your child. These students are near the end of their training and will be supervised by a faculty member from their school. I authorize the use of radiographs, photographs, and records for the purpose of teaching, research, referral to other healthcare providers and scientific publication. I further verify that the medical history is true and accurate to the best of my knowledge. I have read and understood the above information. I will let a staff member know if I have any questions.

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