ATTACHMENT I

Dental Health History

Name ____________________
ID No. ____________________
Birthdate ____________________

In the following questions, circle Yes or No, whichever applies. Your answers will be considered confidental.

1. Do you (PATIENT) have or have you (PATIENT) had any of the following:

Rheumatic Fever or Heart Murmur	Yes	No	Neurological Problems	Yes	No
Heart Trouble or Shortness of Breath	Yes	No	Tuberculosis (TB) or Persistent Cough	Yes	No
High or Low Blood Pressure	Yes	No	Diabetes or Excessive Thirst	Yes	No
Fainting or Dizzy Spells	Yes	No	Epilepsy or Seizures	Yes	No
Stroke	Yes	No	Kidney Problems or Excessive Urination	Yes	No
Anemia or Blood Problems	Yes	No	Liver Problems or Hepatitis	Yes	No
Sickle Cell Anemia	Yes	No	Venereal Disease	Yes	No
Excessive Bleeding or Bruise Easily	Yes	No	AIDS/ARC/HIV Positive	Yes	No
Blood Tranfusions	Yes	No	Cancer	Yes	No
Allergies or Skin Rash	Yes	No	Pregnancy	Yes	No
Asthma	Yes	No	Trimester 1 2 3		
Thyroid Problems	Yes	No	Painful or Swollen Joints	Yes	No
Emotional Problems	Yes	No	Other ____________________	Yes	No

2. Are you (PATIENT) currently under care of a physician (doctor)? Yes No
   If yes, list name of doctor. ____________________

3. Have you (PATIENT) been hospitalized in the last 2 years? Yes No
   If yes, why? ____________________

4. Are you (PATIENT) currently taking any medication, pills or drugs? Yes No
   If yes, list. ____________________

5. Are you (PATIENT) allergic to or ever experienced any ill effects from a local anesthetic (novocain), penicillin, or any drugs/pills? i.e., rash, itching or fainting. If yes, describe. ____________________ Yes No

6. Have you (PATIENT) ever experienced any unfavorable reaction from previous dental treatment? If yes, describe. ____________________ Yes No

7. Are you (PATIENT) currently having any dental pain or problem? Yes No
   If yes, describe. ____________________

I certify that I have read and understand the above questions and have answered the questions to the best of my knowledge. I have asked for an explanation of any terms (words) that I did not know (if any), and my questions have been answered to my satisfaction. I will not hold my dentist, or any of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

I also understand that before treatment is provided, I have the right to have the the benefits, alternatives, and significant risk factors associated with this treatment explained to my satisfaction.

Signature of Patient ____________________ Date __________
(If patient is a child, parent or legal guardian must sign) Relationship ____________________

Comments by Dentist: ____________________
____
____

Signature of Dentist ____________________ Date __________

DH 3117, 10/96 (Part 5) (Replaces HRS-H Form 3117, part 5, which may be used)
(Stock Number: 5744-005-3117-7)

ATTACHMENT II

BAKER COUNTY HEALTH DEPARTMENT
DENTAL PATIENT REGISTRATION

NOTE: THIS FORM IS REQUIRED BEFORE YOUR CHILD CAN BE TREATED!

PLEASE PRINT

PATIENT NAME
FIRST: ____________________ M. INITIAL: __________ LAST: ____________________

ADDRESS: ______________________________ CITY: ______________ ZIP: ________

DRIVING DIRECTIONS: ____

PHONE NUMBER: ______________ SCHOOL: ______________________ GRADE: ______

PATIENT'S SOCIAL SECURITY NUMBER: ____________________ RACE: __________ SEX: __________

PATIENT ON MEDICAID (Y OR N): __________ MEDICAID #____________________

NAME OF PERSON EMPLOYED: ____________________ EMPLOYER: ______________

MONTHLY INCOME: ______________

SS: __________ AFDC: __________ ALIMONY: __________ CHILD SUPPORT: ________

UNEMPLOYMENT: __________ WORKERS COMP: ______________ OTHER UNEARNED INCOME: ______________

PLEASE LIST EVERYONE THAT LIVES IN THE HOUSEHOLD:

	NAME	DOB	SSN	RACE/SEX	RELATIONSHI PATIENT
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

PARENT/GUARDIAN SIGNATURE DATE

BAKER C.A.R.E.S.

(County Alliances Rendering Excellent Smiles)

The Baker C.A.R.E.S. Children's Dental Bus is looking forward to coming to your child's community. The Baker County Health Department in cooperation with your local Health Department and School Board will provide dental services to children on Medicaid. Services provided: dental exams/x-rays, cleanings, sealants, fillings and extractions. Parents who wish to have their children participate should sign the permission slip below.

Please return the permission slip to your child's school. Upon receiving your permission, a health history package will be sent home for you to fill out and return. Your child will not be scheduled for a dental visit until this package is received. Please fill out the packet LEGIBLY and NEATLY. DO NOT LEAVE ANY BLANK SPACES or QUESTIONS UNANSWERED; this will delay your child's care while the papers are being returned to you.

Not all eligible children will be served due to limitations in the number of appointments. We will attempt to provide as much care as our time and resources allow.

If you have any questions, please feel free to contact the staff listed below.

______________________________	______________________________
Maria Larocca, R.N. Clay CHD 904-284-6340 ext. 161	Baker County Health Department 1-866-617-0708 ext. 2282

I give my permission for my child ______________________________, Date of Birth________________, Name of school child attends______________________________to participate in the Baker County Health Department Dental Outreach Program. I also give permission for my child to receive mouth x-rays, local anesthesia and dental treatment which includes cleanings, sealants, fillings and extractions as well as pre or post-op medications that the dentist feels are appropriate.

____________________________________ ______________

Parents or Guardian Signature Date

Baker County Health Department
480 West Lowder Street, Macclenny, FL 32063
(904) 259-6291 ext 2282 or 1-866-617-8708 ext 2282