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. ➡