



Miles for Smiles

OCHC DENTAL CLINIC

PATIENT INFORMATION FORM

Parents of children: The information requested is very important. In order for your child to receive dental care provided by Miles for Smiles, you will need to complete this form for your child. This information form becomes part of our permanent record and will be held in strict confidence. Please circle YES or NO, where indicated. If you are unable to complete this form by yourself, please ask for assistance. If you have questions, call Miles for Smiles at 417-328-6334. Thank you!

Date _____ School _____ Teacher's Name _____

Name of Patient _____ Grade Level _____

Medicaid No. _____ HMO (Medicaid Insurance) Name _____

Self Pay (must call office)

Private Insurance: Type of Insurance _____ Policy Holder _____

ID# or SS# of Policy Holder _____ DOB of Policy Holder _____

Customer Service # _____

DOB _____ Age _____ Year _____ Months Male Female Height _____ Weight _____

Home Address _____

Telephone Number Home _____ Business/ALT _____

Has your child seen a dentist before? YES NO If yes, have they been within the last 6 months? YES NO

Please check the reason(s) for seeking dental care? Routine checkup First visit Toothache Accident to teeth

Other (specify) _____

DENTAL AND MEDICAL HISTORY (please circle YES or NO where indicated)

- | | | |
|---|-----|----|
| 1. Has the child had an unusual or unpleasant experience in a dental or medical office? | YES | NO |
| 2. Has the child ever had any injuries to the face, mouth or teeth? | YES | NO |
| 3. Has the child ever had a toothache? | YES | NO |
| 4. Does the child have any oral habits such as thumb sucking? | YES | NO |
| 5. Is the child presently in good health? | YES | NO |
| 6. Is the child's immunization records up to date? | YES | NO |
| 7. Were there any problems during pregnancy, delivery or during the child's first year? | YES | NO |
| 8. Does your child take any fluoride supplements? | YES | NO |
| 9. Does your child have a history of allergies? | YES | NO |
| 10. Tylenol for children may be given by school nurses for discomfort based on school policy. | YES | NO |

What pharmacy do you use? _____

Is your child under a physician's care now? YES NO If yes, please explain _____

Has your child ever been hospitalized or had major operations? YES NO If yes, please explain _____

Is your child taking any medications, pills or drugs? YES NO If yes, please list _____

Is your child allergic to any of the following? _____ Aspirin _____ Penicillin _____ Codeine _____ Acrylic _____ Metal
_____ Latex _____ Local Anesthetics _____ Other If yes, what _____

Does your child use tobacco? YES NO

Does your child use a controlled substances? YES NO

Does your child have any heart problems that require antibiotics before dental treatment? YES NO

Race:

____ African American/Black

____ Asian

____ Caucasian/White

____ American Indian/Alaska Native

____ Native Hawaiian/Pacific Island

____ Some other Race

____ Pt unable to provide

Ethnicity:

____ Hispanic or Latino

____ Not Hispanic or Latino

Primary Language:

____ English

____ Korean

____ Other

____ Romanian

____ Sign

____ Spanish

____ Vietnamese

Patient Information:

Monthly Income: \$ _____

Household Size: _____

Does your child have or had any of the following?

- | | | | | |
|---|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Herpes | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Tumor or Growths |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Yellow Jaundice |

Has your child ever had any serious illness not listed above? YES or NO If yes, explain _____

CONSENT AND AGREEMENT

Our staff will answer any questions about consent and agreement forms that are not clear. I hereby give consent to the Dentist of Miles for Smiles and dental auxiliaries working under the dentist's supervision to perform on _____ my son/daughter/ward, those procedures and treatment including anesthesia and in the administration of drugs common to dental practice. **The services could include cleaning, exam, x-rays, fluoride treatments, sealants, extractions, fillings, crowns, root canal, space maintainers, etc. as needed.** I am aware that the risks are essentially the same as those procedures performed in a hospital or private dentist's office (for example: possible allergic reactions to anesthetic or possible accidental cuts or abrasions). "I understand that in some instances my child's oral screening, teeth cleaning, fluoride treatments, x-rays, and sealants may be performed by a dental hygienist without the presence or supervision of a dentist as permitted by law under §332.311 of the Revised Statutes of Missouri (2006) and 19 CSR § 10-4.040. In this case, a dentist of Ozarks Community Health Center may perform an examination via our secure Electronic Medical Record (EMR)." Further, I certify that I understand and agree to the conditions set forth above. I also understand I am free to ask any questions regarding the procedure and risk involved and that a copy of the privacy policy is available on our website. I give my permission to OCHC Miles for Smiles to bill my insurance accordingly.

Signature of Parent/Guardian: _____ Print Name: _____

Parent/Guardian Phone Number: _____ Parent/Guardian Date of Birth: _____

Relationship to Patient: _____ Date: _____

FOLD HERE

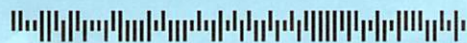


NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 125 HERMITAGE, MO

POSTAGE WILL BE PAID BY ADDRESSEE

MILES FOR SMILES
OZARKS COMMUNITY HEALTH CENTER
102 JACKSON
PO BOX 125
HERMITAGE MO 65668-9902



***This consent is valid for one year from the date signed.

FOLD HERE

TAPE HERE TO CLOSE