Miles of Smiles Mobile Dental Clinic

252-241-4492

Carteret County Health Department * 3820-A Bridges Street, Morehead City, NC 28557

Patient Name:_____

Date of Birth:_____ Sex:_____Race:_____

Address_____

_____

Medicaid ID #:_____

Phone Number_____

e-mail Address_____

Emergency Contact Name:_____

Relationship & Phone #:_____

Are you allergic to any of the following? (Circle those that apply.)

Aspirin	Penicillin	Codeine	Acrylic
Metal	Latex	Sulfa Drugs	Local Anesthetics
Other			

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's / OB care?	Yes	No
Explain:		
Have you ever been hospitalized or had a major operation?	Yes	No
Explain:		
Have you ever had a serious head or neck injury?	Yes	No
Explain:		
Are you taking any medications, pills or drugs?	Yes	No
Explain:		
Are you on a special diet?	Yes	No
Explain:		
Do you use tobacco, vape, chew or dip?	Yes	No
Explain:		
When was your last Dental visit and cleaning?	Yes	No
Explain:		
WOMEN: Are you or are you trying to get Pregnant?	Yes	No
WOMEN: Are you Nursing?	Yes	No
WOMEN: Are you taking oral contraceptives?	Yes	No

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Radiation Treatments	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Recent Weight Loss	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Renal Dialysis	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Rheumatic Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Rheumatism	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	High Cholesterol	Yes	No	Scarlet Fever	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hives or Rash	Yes	No	Shingles	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Hypoglycemia	Yes	No	Sickle Cell Disease	Yes	No
Asthma	Yes	No	Fainting Spells/ Dizziness	Yes	No	Irregular Heartbeat	Yes	No	Sinus Trouble	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Kidney Problems	Yes	No	Spina Bifida	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Leukemia	Yes	No	Stomach/ Intestinal Disease	Yes	No
Breathing Problems	Yes	No	Frequent Headaches	Yes	No	Liver Disease	Yes	No	Stroke	Yes	No
Bruises Easily	Yes	No	Genital Herpes	Yes	No	Low Blood Pressure	Yes	No	Swelling of Limbs	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Lung Disease	Yes	No	Thyroid Disease	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Mitral Valve Prolapse	Yes	No	Tonsillitis	Yes	No
Chest Pains	Yes	No	Heart Attack/ Failure	Yes	No	Osteoporosis	Yes	No	Tuberculosis	Yes	No
Cold Sores/ Fever Blisters	Yes	No	Heart Murmur	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pacemaker	Yes	No	Psychiatric Care	Yes	No	Ulcers	Yes	No
Convulsions	Yes	No	Heart Trouble/ Disease	Yes	No	Acid Reflux/ Morning Sickness	Yes	No	Venereal Disease	Yes	No
Yellow Jaundice	Yes	No	Anxiety/ Depression	Yes	No						
List any other serious illnesses not listed above:											
DENTAL HISTORY:						Fear of Needles	Yes	No	Gagging Problems	Yes	No
						Bad Experience	Yes	No	TMJ	Yes	No

Opt IN to Text Messaging? **YES** *or* **NO** *Telephone:* _____ *Initials:* _____

**Your cellular provider may charge for texting.*

MUST READ AND SIGN BOTH SIDES OF THIS FORM

CONSENT FOR DENTAL TREATMENT

Miles of Smiles Mobile Dental Clinic 252-241-4492

Carteret County Health Department

Please read form carefully.
If there is anything you do not understand or have questions, please contact us at 252-241-4492

Patient Name_____ DOB_____

I grant permission to receive dental care at the *Miles of Smiles Mobile Dental Clinic*. I authorize the dentist to perform any indicated diagnostic procedures and/or dental treatment which he/she feels necessary in providing quality dental care.

DENTAL TREATMENT MAY INCLUDE:

- **Examination** – comprehensive oral examination by dentist which may include cleaning, fluoride treatment and x-rays
- **Sealants** – material placed into grooves of the tooth to protect from cavities
- **Fillings** – white (composite) or silver (amalgam) material that is used to fill a tooth after the cavity (decay) is removed
- **Extraction** – tooth is removed when it has a very large cavity and cannot be restored with a filling
- **Pulpotomy** – when a tooth has a very large cavity that has reached the nerve of the tooth and requires a special nerve treatment
- **Stainless Steel Crown** – a silver crown that is placed over a tooth that cannot be filled due to a large cavity
- **Nitrous Oxide** – a mild sedative gas may be used to calm the patient if needed
- **Six Months Follow Up** – Exam, Cleaning and Fluoride

I understand that services provided for some dental conditions may be limited in scope and are intended to provide relief from pain, bleeding, swelling, infection or injury.

I understand that most services provided by the *Miles of Smiles Mobile Dental Clinic* are routine dental procedures that normally present little risk to the patient. However, I have been advised that, as with any dental treatment, there are some risks of complications. These risks include, but are not limited to: the possibility of pain or discomfort, swelling, infection, bleeding, injury to surrounding teeth and soft tissues, the development of jaw joint (TMJ) disorders, temporary or permanent numbness and allergic reactions.

I accept these terms for treatment and give consent for dental care to be provided. I understand that this consent for dental treatment will remain in effect as long as I am eligible for the program. Should I wish to no longer receive dental treatment through the Miles of Smiles Mobile Dental Clinic, I will notify a member of the dental clinic staff in writing.

I acknowledge that I have read and understand this Consent Form, that I have been given an opportunity to ask any questions I may have and that all questions have been answered to my satisfaction.

SIGNATURE IS REQUIRED FOR TREATMENT

_____

Signature of Patient Consenting to Treatment Date