COVENANT COMMUNITY CARE
"I WAS SICK AND YOU LOOKED AFTER ME" MATTHEW 25:36

School Based Dental Team

Site: **Teacher's name/ Classroom #**

PATIENT INFORMATION					
Name		Date	Date of Birth:		
Address	Apt #	City	State	Zip Code	
Gender (M) (F)		**Social Security #:**	**Medicaid #:**		
Cell Phone: ( )		May we text this phone # (YES) (NO)	Parent's Name:		
E-Mail Address					

HEALTH INFORMATION Please mark with (X) to all that apply:

AIDS		Diabetes		Head Injuries		Liver Disease		Sinus Problems	
Allergies		Dizziness		Heart Disease		Mental/Nervous Disorder		Stomach Problems	
Anemia		Epilepsy		Heart Murmur		Pacemaker		Stroke	
Arthritis		Excessive Bleeding		Hepatitis		Pregnancy		Tuberculosis	
Artificial Joints		Fainting		Herpes		Due Date:		Tumors	
Asthma		Glaucoma		High Blood Pressure		Radiation Treatment		Ulcers	
Blood Disease		Growths		Jaundice		Respiratory Problems		Venereal Disease	
Cancer		Hay Fever		Kidney Disease		Rheumatic Fever			

List all medications: Include prescriptions, over the counter and herbal supplements you take routinely:

Are you allergic to any of the following:	Yes	No	Penicillin	Yes	No	Aspirin
List Other Allergies:	Yes	No	Codeine	Yes	No	Dental Anesthetics
	Yes	No	Sulfa Drugs	Yes	No	Clindamycin
	Yes	No	Erythromycin	Yes	No	Latex
Are you now under the care of a physician?	YES	NO	What was the date of your last dental visit?			Reason for the visit?

PERMISSION FOR DENTAL SERVICES: Covenant Community Care will provide these dental services: Exam, Cleaning, Fluoride, Sealants, possible restorative care and a dental report card.

BY SIGNING THIS YOU ARE:

Authorizing and giving consent to allow Covenant Community Care to provide preventive dental treatment. Acknowledging you have received a Notice of Privacy Practices. Granting the authority to Covenant Community Care, Inc. the right to take photographs/ videos. Granting the authority to Covenant Community Care, Inc. to copyright, use and publish the same in print and /or electronically with or without your name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content. **Agreeing to allow Covenant Community Family Dental Center to bill your insurance or Medicaid for reimbursement**.

PRINT NAME:

X Signature*:*

***(Circle)* Parent or Guardian**

PRIVATE INSURANCE INFORMATION: Name of the Insured:			Is the patient the insured?	YES	NO
Insured's birth date	Subscriber/ Policy #		Group #		
Patient's relationship to the Insured	Self	child	Insurance Plan's name		

PATIENT DEMOGRAPHIC INFORMATION: Please check the boxes that describe your status. Covenant Community Care Family Dental Center is a non-profit public health facility. The information below is vital for future funding of this clinic. Thank you for taking your time to complete this important information.

Race	Native Hawaiian		Other Islander		Asian		Caucasian	
	Black/African American		American Indian		Hispanic/Latino		Other	
Language	English	Spanish	Others		Sign Language		Arabic	
Worker Status	Migrant	Seasonal						
Homeless	Shelter	Street	Transitional		Doubling Up		Other	
US Veteran	Yes	No						
Income Data	Family Size/ Household #				Household annual income: $			

Please return this form to the SCHOOL OFFICE