VISIT DATE _____ **CENTRAL CITY INTEGRATED HEALTH** **SCHOOL NAME** _____

Central City Dental Center

10 Peterboro, Detroit, MI 48201
(313) 309-3091

SERVICES TO BE PROVIDED: COMPLETE EXAM, X-RAYS, ORAL ASSESSMENT, CLEANING, ORAL HYGIENE INSTRUCTIONS AND EDUCATION. ADDITIONAL SERVICES MAY INCLUDE FLUORIDE GEL OR VARNISH AND SEALANTS, AS APPROPRIATE.

PATIENT INFORMATION

Last Name _____ First Name _____ M.I. _____ Birthdate _____ Male ☐ Female ☐

Street _____ City _____ State _____ ZIP Code _____

Main Phone _____ Home ☐ Cell ☐ Work ☐ Second Phone _____ Home ☐ Cell ☐ Work ☐

Primary Language of Student _____

Race (Check One)

☐ Asian ☐ American Indian/Alaska Native
☐ Native Hawaiian ☐ White
☐ Other Pacific Islander ☐ More than one race
☐ Black/African American ☐ Refuse to Answer

Ethnicity

☐ Hispanic or Latino
☐ Not Hispanic or Latino

PARENT/GUARDIAN INFORMATION

Parent/Guardian Full Name _____ Parent DOB _____

Parent SS # _____ Relationship to Student _____

Home address if different from student: _____

Phone _____ Home ☐ Cell ☐ Work ☐

DENTAL INSURANCE INFORMATION

☐ **MEDICAID: Please enter 8 or 10 digit Medicaid #:** _____

☐ Private Insurance

Insurance Company Name _____ Insurance Phone _____

Employer _____ Group # _____ Insurance # _____

Subscriber _____ Subscriber DOB _____ Subscriber SSN _____

☐ No Insurance*

***Medicaid application assistance is available at the Central City Integrated Health office located at 10 Peterboro, Detroit, MI 48201.**

PLEASE NOTE: ALL TREATMENT PROVIDED BY CENTRAL CITY INTEGRATED HEALTH MAY BE OBTAINED AT THE PATIENT'S DENTAL HOME RATHER THAN AT A MOBILE DENTAL FACILITY AND THAT OBTAINING DUPLICATE SERVICES AT A MOBILE DENTAL FACILITY MAY AFFECT BENEFITS THAT MAY BE RECEIVED FROM PRIVATE INSURANCE, A STATE OFFERED INSURANCE, OR OTHER THIRD-PARTY PROVIDERS OF DENTAL BENEFITS.

I (Parent/Legal Guardian) give my consent for the above-named student to receive services listed in this form from CENTRAL CITY INTEGRATED HEALTH (CCIH). By signing this consent form, I confirm that I am the custodial parent and/or legal guardian of the above-named student and that the insurance information is current and correct. I understand that I may withdraw my consent for services upon written notice to CCIH at any time. I understand that signed consent gives authorization for initial preventive care visit(s) and additional 6-month check-ups. I authorize CCIH and my child's primary care physician or established health care providers to exchange health care information for the purpose of continuity and coordination of care. I acknowledge a copy of CCIH's Notice of Privacy Practices and CCIH's Patient Rights and Responsibilities is available to me upon request.

Parent/Legal Guardian Signature _____ **Date** _____

Central City Dental Center

School Name _____ Birthdate _____

Patient's Name _____

MEDICAL HISTORY

GENERAL HEALTH: ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

☐ Y ☐ N Under physician/mental health provider's care now? Primary Care Physician's name and phone #: _____

☐ Y ☐ N Any hospitalization in the past 5 years? _____

☐ Y ☐ N Any serious illnesses/surgeries? _____

☐ Y ☐ N Is pre-medication required before dental visits due to heart condition, artificial joint or any other condition?

☐ Y ☐ N Taking any prescription or daily OTC medications/drugs? If yes, list details in the Medication Section.

Is there anything about your medical condition we have not asked? If yes, please describe:

_____

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐ **NONE**

☐ Acid Reflux	☐ Bulimia	☐ Hearing Problems	☐ Psychiatric Treatment
☐ ADHD	☐ Cancer/Malignancy	☐ Heart Attack	☐ Radiation/Chemo
☐ AIDS/HIV	☐ Cerebral Palsy	☐ Heart Disease	☐ Respiratory Disease
☐ Anemia	☐ Chemical Dependency	☐ Heart Murmur	☐ Rheumatic Fever
☐ Anorexia	☐ Chicken Pox	☐ Hepatitis	☐ Sinus Problems
☐ Anxiety	☐ Convulsions	☐ High Blood Pressure	☐ Stroke
☐ Artificial Heart Valve	☐ Depression	☐ Kidney Disease	☐ Thyroid Condition
☐ Artificial Joints	☐ Diabetes	☐ Liver Problems	☐ Tuberculosis
☐ Arthritis	☐ Dizziness/Fainting	☐ Mitral Valve Prolapse	☐ Ulcers
☐ Asthma	☐ Epilepsy/Seizures	☐ Mononucleosis	☐ Venereal Disease
☐ Autism/Asperger's	☐ Frequent Ear Infections	☐ Pacemaker	
☐ Bleeding Disorder	☐ Frequent Headaches	☐ Other - Please list:	

Other - please list: _____

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY): ☐ **NONE**

☐ Aspirin	☐ Codeine	☐ Lactose Intolerance	☐ Sleeping Pills
☐ Anesthetic - Local	☐ Dairy	☐ Metal Sensitivity	☐ Sulfa Drugs
☐ Barbiturates	☐ Latex	☐ Nitrous Oxide Sedation	☐ Penicillin/Other Antibiotics
☐ Other - Please list:			☐ Nut/Food

Other - please list: _____

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐ **NONE**

☐ Antibiotics/Sulfa Drugs	☐ Antihistamines/Allergy	☐ Daily Aspirin	☐ Blood Pressure Medications
☐ Blood Thinners	☐ Cancer/Chemo Medications	☐ Cortisone/Steroids	☐ Heart Medication/Digitalis
☐ Insulin	☐ Nitroglycerin	☐ Pain Relievers	☐ Osteoporosis Medications
☐ Other Diabetic Medications	☐ Thyroid Medications	☐ Anxiety/Depression/Bipolar	
☐ Other (Please List Below)	☐ Seizures		

DRUG NAME	DOSAGE	REASON PRESCRIBED

Parent/legal guardian signature: _____ **Date:** _____

Reviewed by: _____ **Date:** _____