Oral Health Eligibility and Medical History Form

Medical Alert_____

Patient Number: _____

WELCOME

We are pleased to welcome you to Clayton County Health District. Please take a few minutes to fill out this form as completely as you can. If you have questions, we will be glad to help you. We look forward to working with you in maintaining your oral health.

Patient's Name:_____
Last First Middle

Address:_____
Street City Zip County

Home Phone:(_____)_____ SSN#:_____
Area Code

Birth Date: ____/____/_____ Age: _____ Sex: M____ F____ Race: _____

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Father's/Guardian Name: _____ SSN#: _____
Employer: _____ Work Phone: _____

Mother's/Guardian Name: _____SSN#: _____
Employer: _____ Work Phone: _____

Emergency Contact Person: _____ Phone: _____

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Medical eligible? Yes___ No ___ Medicaid Number: _____
Other Dental Insurance? Yes___ No ____ Company Name _____
Policy Number: _____ Group Number: _____

Family Income: Weekly $_____ Monthly $ _____ Yearly $ _____

Total Number In Family: _____ *Include children and adults*

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Does Patient attend school? Yes_____ No _____ Name of School: _____

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Patients under 18 years of age must have the medical history and consent signed ***in ink*** by a parent or legal guardian before treatment begins.

***** PLEASE COMPLETE AND SIGN MEDICAL HISTORY FORM *****


DPH
GEORGIA DEPARTMENT OF PUBLIC HEALTH
Clayton County Health District