MARION COUNTY PUBLIC HEALTH DEPARTMENT

Prevent. Promote. Protect.

Name: ________________________ Date of birth: __________ MCPHD#____________

**Please cirlce any of the following, which the patient has had or has currently:**

1. ADHD/ADD
2. Alcoholism
3. Anemia
4. Arthritis
5. Artificial heart valve
6. Asthma or hay fever
7. Blood transfusions
8. Bruise easily
9. Cancer or tumor
10. Chemotherapy
11. Chest pains
12. Cold sores
13. Cortisone medication
14. Diabetes
15. Drug addiction
16. Emphysema
17. Epilepsy or seizures
18. Fainting or dizzy spells
19. Fever
20. Glaucoma
21. Heart attack or stroke
22. Heart condition
23. Heart murmur
24. Heart pacemaker
25. Heart surgery
26. Hemophilia
27. Hepatitis
28. Herpes
29. High blood pressure
30. Hip/joint replacement
31. HIV/AIDS
32. Kidney trouble
33. Liver disease
34. Lung disease
35. Night sweats
36. Osteoporosis
37. Pain in jaw joints
38. Psoriasis
39. Psychiatric treatment
40. Radiation therapy
41. Rheumatic fever
42. Shortness of breath
43. Sickle cell anemia
44. Sickle cell trait
45. Skin rashes or hives
46. Swelling of ankles
47. Thyroid disease
48. Tuberculosis (TB)
49. Venereal disease
50. Weight loss
51. Yellow jaundice

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1. Have you ever received any health-related service from the Marion County Public Health Department. Yes No
2. Do you have any diseases, conditions or problems not listed above? Yes No
3. Are there any activities in gym class, athletics or other physical activities restricted in any way? Yes No
4. Are you presently taking any medicine or drugs? Yes No
   List medication(s), dosage and directions
   ________________________
   ________________________
   ________________________
5. Have you ever taken Fen-phen/Redux? Yes No
6. Are you now or have you been under the care of a physician during the last two years? Yes No
7. Have you ever been hospitalized or had surgery? Yes No
8. Are you allergic to latex? Yes No
9. Are you allergic to any medicine, drug or other substance? Yes No
   If "yes", please list:
   ________________________
   ________________________
   ________________________
10. Have you ever had a reaction to local anesthetic? Yes No
11. Have you ever had a prolonged or unusual bleeding? Yes No
12. Have you ever had complications or illness following dental treatment? Yes No
13. Have you ever had any injury or trauma to your face or jaw? Yes No
14. Do you smoke or use smokeless tobacco? Yes No
15. Are you nervous or concerned about having dental work done? Yes No
16. Women:
    Are you pregnant? Due date: ________ Yes No
    Do you use birth control? Yes No
    Do you anticipate becoming pregnant? Yes No
    Have you had any complications or problems with previous pregnancies? Yes No
17. Do you presently have a dentist? Yes No
    Dentist's Name: ________________________
    Address: ________________________
18. Are you having dental pain or discomfort at this time? Yes No
19. Why are you seeking dental treatment?
    ________________________
    ________________________
    ________________________

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To the best of my knowledge, all of the preceding answers are true and correct. If I ever have a change in my health, or if my medicines change, I will inform the doctor at the next appointment. Specific dental procedures will be explained to me. I understand that I/my child may not be able to receive all of the desired services from the Marion County Public Health Department and my treatment may require the need for me to be referred to other dental practitioners due to the nature of my dental problem. I understand that all dental procedures have benefits as well as certain risks, including possible side effects from some medicines used in dentistry and that these risks include, but are not limited to allergic reactions, cuts/abrasions, tenderness/bruising from injections, sensitive teeth, swallowing inhaling dental materials/prosthesis and infections or serious complications or conditions.

Patient/Parent/Guardian signature: ________________________ Date: ____________

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I also authorize and agree that the Health and Hospital Corporation of Marion County may keep or compile health information in any manner and is hereby authorized to use any treatment records, x-rays or photography for teaching or research purposes, including scientific journals or government-related publications. Patient confidentiality will be protected. Patient's name or other private identifying information will not be released.

Patient/Parent/Guardian signature: ________________________ Date: ____________

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I hereby authorize insurance benefits to be paid directly to the dentist or their representative (Health and Hospital Corporation). I also authorize the dentist or other appropriate staff or representative to release information required to process claims and agree that a photocopy of this authorization is as valid as the original. I also agree that the Marion County Public Health Department may release a copy of my medical/dental record, or any portion thereof, or other information to the health professionals involved with my medical/dental care.

Patient/Parent/Guardian signature: ________________________ Date: ____________

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