

Reason for Visit: Check any that apply (✓)

- First examination
 Couldn't afford dental care
 Couldn't get appointment anywhere else
 Toothache/mouth pain/face swelling
 Other (specify) _____

Patient Behavior	Yes	No	
Does the patient brush daily?			
Does the patient drink soda pop or other sugar sweetened drinks daily (Kool-aid, fruit drink, Gatorade, sport drinks)?			
Is the patient using tobacco products (cigarettes, chewing tobacco, smokeless tobacco)?			
Does anyone in the household use tobacco products (cigarettes, chewing tobacco, smokeless tobacco)?			

Insurance: Please WYW any that apply. If Medicaid or private dental insurance, please indicate Medicaid number or policy number in the space provided.

MUST PROVIDE A COPY OF YOUR DENTAL INSURANCE CARD IF APPLICABLE.

Medicaid/ SCHIP
 Private DENTAL Insurance (please provide copy of card)
 None
 Medicaid Number/ Policy Number _____

Dental Ins. Name: _____ policy # _____ group # _____


Dental Ins. Address: _____ Ins. Phone # _____

Employer Name: _____

Treatment Consent and Agreement

I, _____, as a legally responsible guardian of _____
(print parent/legal guardian name) (print child's name)
 give my consent for the dental services I have authorized below. I understand there may be risks involved with dental treatment. Please note that preventive dental hygiene services alone, provided outside of a regular dental office, should not replace regular dental exams by a dentist. Each item needs to be answered in order to receive dental care.

Yes	No	
		Preventive Services: screening by a hygienist, teeth cleaning, oral hygiene instruction, sealants, fluoride treatment.
		Dentist Exam (including dental x-rays)
		Restorative Services: fillings, stainless steel crowns, pulpotomy. Local anesthetic may be used for these procedures.
		Extractions: removal of primary (baby) or permanent teeth that cannot be restored through other treatments. Local anesthetic may be used for these procedures.
		The use of nitrous oxide (laughing gas) may be used as deemed necessary.
		I have been offered and/or read a copy of the Delta Dental's HIPAA Notice of Privacy Practices.


 Parent/Legal Guardian signature _____ Date _____