Medical Alert:

CONSENT & MEDICAL HISTORY FOR DENTAL SERVICES

FIRST NAME: _____ LAST NAME: _____

DATE OF BIRTH: MONTH ____ DAY ____ YEAR _____

ADDRESS: _____

PHONE NUMBER: _____ WORK NUMBER: _____

EMAIL: _____

EMERGENCY CONTACT: _____ PHONE NUMBER: _____

IMPORTANT MEDICAL INFORMATION

Do you have an allergy to (please circle): Medications Latex Colophony (adhesive/plastic resin) Other:

Have you ever taken an antibiotic before dental treatment? YES ☐ NO ☐

Have you ever been hospitalized or had a serious illness? _____ YES ☐ NO ☐

Do you have asthma and require an inhaler? YES ☐ NO ☐

Are you taking any medications? Please list: _____ YES ☐ NO ☐

_____

Have you ever had a reaction to dental treatment or anesthetic? _____ YES ☐ NO ☐

Please indicate all that apply:

	substance abuse ☐	abnormal bleeding ☐	chest pain ☐	had surgery ☐
mental disorder ☐	stroke ☐	epilepsy/seizures ☐	diabetes ☐	joint replacement ☐
cancer ☐	sinus problems ☐	STD ☐	rheumatic fever ☐	pregnant ☐
high/low blood pressure ☐	kidney disease ☐	fainting ☐	hepatitis ☐	HIV/AIDS ☐
heart attack/surgery ☐	lung disease ☐	tuberculosis ☐	asthma ☐	anxiety ☐
				cold sores ☐

Other: _____

Have you seen a dentist within the last year? YES ☐ NO ☐

Do you have any kind of dental coverage? Healthy Smiles Interim Federal Health Private YES ☐ NO ☐
Information:

I DO NOT WANT TO RECEIVE THE FOLLOWING TREATMENT:

_____

By signing, I understand that I am giving consent, and warrant that I have legal authority to do so, for oral health services provided by smileMOBILE which may include but is not limited to: x-rays, exams, restoration, debridement, preventative services, and oral surgery, unless otherwise indicated above.
I am aware that I can withdraw my consent by requesting a consent withdrawal in writing or by speaking to a coordinator or director of smileMOBILE. I understand that my consent is carried forward if treatment is continued at a different location by different providers.
I agree that I have been informed about indicated treatment and my questions have been answered to my satisfaction. I understand that I will not receive treatment or services without providing consent.

SIGNATURE OF PERSON RECEIVING TREATMENT IF 18YRS OR OLDER: _____

SIGNATURE OF PARENT/GUARDIAN/REPRESENTATIVE: _____

PRINT NAME: _____ DATE: _____

Please tell us if you have guard.me insurance or MSP insurance:

Please tell us if you are experiencing pain or discomfort with your teeth or gums:

Please confirm that you will be available between 8:30am and 4:30pm on Saturday, October 21 2023: