WILKES PUBLIC HEALTH
DENTAL CLINIC
1915 West Park Drive, Suite 104
North Wilkesboro, NC 28659

Children's Clinic: 903-9399
Adult Clinic: 903-7300
Mobile Clinic: 903-7303
Clinic Fax: 903-0464

CHILD REGISTRATION

We are excited to inform you that the Wilkes Public Health Mobile Dental Clinic will be visiting your school/site/center. Our mission is to serve children and adults in Wilkes County who are unable to receive dental treatment due to lack of transportation or income.

If you are interested in our services, please fill out this form completely and return it to your school/site/center as soon as possible. Any incomplete forms will result in treatment not being rendered.

If you have any questions or if your contact information changes in any way, contact the Mobile Dental Clinic as soon as possible @ 336-903-7303 or 336-928-0047.

A current copy of the child's dental coverage verification or card is required at each visit, prior to treatment. Please attach a copy to this form before returning it to your school/site/center

____**YES**, I am interested in my child being treated in the Mobile Dental Clinic.

____**NO**, I am not interested.

I hereby request the Mobile Dental Clinic staff to perform a dental exam, cleaning, fluoride treatment, x-rays and preventive sealants for my child. I understand that any further dental needs will be explained to me in writing and that I must sign and return the written consent prior to the treatment being completed. I also agree to the exchange of information with my child's school personnel in order to assist with parent contact and student treatment.

Parent/Guardian Signature: ________________________ ***Date:*** ____________

Patient/child name: Last ________________ **First** ________________ **MI** __________
School/Site/Center ___________________________ **Grade & Teacher** ____________
Sex: M___ **F**___ **Age**___ **Birthdate:** _________ **Race:** _____ **Social Security #:** _________
Address: ______________________________ **Home Phone:** ________________
______________________________ **Cell Phone:** ________________
______________________________ **Emergency Phone:** ____________

Has this child been treated on the Mobile Dental Clinic before? Yes____ **No** ____

This child has: **Medicaid** ___ **Health Choice** ___ **Private insurance** ___ **Self pay**____

I understand that I am financially responsible for all charges, regardless of benefit coverage. I hereby authorize Wilkes Mobile Dental Clinic to release all necessary information to secure payment of benefits. I authorize the use of my signature on all benefit claims submissions, whether manual or electronic.

Turn page over to complete back side!!→→→→→→→→→

DENTAL HISTORY

Date of last dental exam? ________________________ For what reason? ________________

Name of last dentist? ____

Has child ever taken a prescription fluoride supplement? YES__________ NO__________

Has child ever had any of the following: (please briefly explain)

-unhappy dental experiences ____

-any allergic reactions to any dental treatment or materials ______________________

-injuries to head or mouth____

-any concerns about teeth____

-any habits: thumb sucking ______ nail biting ______ pacifier _______ sleeping w/bottle ______

MEDICAL HISTORY

Date of last medical exam _______________ **Physician's name**________________________

Please PLACE A CHECK on all YES answers:

__HEART DISEASE/HEART ATTACK
__ADD/ADHD/ODD
__CONVULSIONS/EPILEPSY/FAINTING
__STOMACH PROBLEMS/ULCERS/REFLUX
__ASTHMA/INHALER USAGE
__AUTISM/ASPERGERS
__COLD SORES/MOUTH ULCERS
__DIABETES
__PHYSICAL DISABILITY
__MENTAL DISABILITY
__CLEFT LIP/PALATE
__ARTHRITIS
__KIDNEY/BLADDER DISEASE
__LIVER DISEASE
__ALCOHOL USAGE/RECREATIONAL DRUGS
__SEXUALLY TRANSMITTED DISEASE
__TUBERCULOSIS
__AIDS/HIV
__CANCER
__EVER BEEN PREGNANT
__TOBACCO USE OR SMOKE
__ANEMIA
__MRSA
__PREGNANCY/BIRTH CONTROL
__HEPATITIS (A, B, or C)
__HIGH BLOOD PRESSURE
__BLEEDING DISORDERS
__THYROID DISEASE
__EVER HAD SURGERY/HOSPITALIZED, please explain: ______________________________
__ALLERGIES to Foods/Seasonal, please explain: ______________________________
__ALLERGIES to Medications/Latex, please explain: ______________________________

*Please list all current medications including Prescriptions, Over the Counter Medications and Herbal Supplements:

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BP_________ Pulse___________ Respirations _________ PSR_____________

All information is true and correct to the best of my knowledge. I will inform the Mobile Dental Clinic staff of any changes.

Patient/Guardian signature: ______________________________ ***Date***: _____________

Dentist signature: ______________________________ ***Date***: _____________