Second Street Health Center
CCS Dental Services
FQHC – Federally Qualified Health Center
60 Second Street, Auburn, ME 04210
Tel (207) 755-3456 Fax (207) 755-3457

How did you hear of us? ____ Dr's Referral ____ Friend ____ Facebook ____Other

PATIENT INFORMATION:				
Last Name	**First Name**	**M.I.**	**Date of Birth**	**Gender M F**
Address	**City**	**State**	**Zip Code**	
Telephone- Home	**Telephone-Work**		**Cell phone**	
Social Security #				
Name of BOTH Parents/Legal Guardian *(ONLY IF UNDER 17 YEARS OF AGE)*				
Is the above a permanent address? Yes No		**Veteran: Yes No**		**Homeless: Yes No**
RACE (PLEASE CIRCLE BELOW):		**ETHNICITY: Hispanic or Latino / NON-Hispanic or Latino**		
White---American Indian or Alaska Native--- Asian--- Black or African American--- Hispanic or Latino--- Native Hawaiian or other Pacific Islander----Somali or Somali Bantu--- Oromo---- Sudanese---- Congolese—Togolese--- Ethiopian----- Unknown or Other				
Primary Language Spoken:		**Interpreter Needed: Y or N**		
Interpreter's Name		**Interpreter's Phone #**		
INSURANCE INFORMATION- please provide copy of card				
MaineCare Policy#:				
PREVIOUS DENTIST:				
Name				
EMERGENCY CONTACT INFORMATION				
Name	**Relationship**	**Telephone-Home**	**Telephone- Work**	

1. **I understand that in providing or arranging these health care services, Community Clinical Services Dental Program will learn personal information about me, but that information shall remain confidential.**
2. **I agree on behalf of myself or my minor child that Community Clinical Services may share medical/dental information with other parties for continuation of as appropriate.**
3. **I authorize my insurance carrier to pay benefits directly to my provider.**

X_____ _____

Signature of Parent/Guardian Date

FOR OFFICE USE ONLY			
Received	**Registered**	**Appointment**	**Provider**

Dental Medical History Form

Patients Name: _____|_____|_____ Date Of Birth: _____/_____/_____
Last First Initial

Parents/Guardian Name_____

COMMENTS:

DENTAL HISTORY *Circle the appropriate answer:*

1. Is this your first visit to a dentist? …… Yes No
2. If not, how long since the last visit to the dentist?……
3. Were any x-rays or radiographs taken when you visited the dentist? …… Yes No
4. Do you eat between meals?…… Yes No
5. Do you eat sweets, such as candy, soda pop and chewing gum etc? …… Yes No
6. When do you brush his/her teeth?
   - ❑ Upon arising
   - ❑ After eating any food
   - ❑ Right after meals
   - ❑ Before going to bed

7. How do you receive fluoride?
   - ❑ Community water level _____ ppm
   - ❑ Well water level ___ ppm
   - ❑ Fluoride drops or tablets
   - ❑ Fluoride rinse or gel

8. Have any cavities been noted in the past? …… Yes No
9. Were any teeth (baby or permanent) removed by extraction? …….. Yes No
   - ❑ Was it suggested that the space be maintained? …… Yes No
   - ❑ Was an appliance placed? …… Yes No

10. Have there been any injuries to teeth, such as falls, blows, chips, etc.? …….. Yes No
    If so describe: ……
11. Have you had a problem with dental treatment in the past? …….. Yes No
12. Has anyone in the family, including parents, had orthodontics? …… Yes No
13. Have you ever received a local anesthetic? …… Yes No
14. Have you ever had occlusal sealants? …….. Yes No
15. Do you think there is anything wrong with your teeth? …… Yes No

MEDICAL HISTORY

1. Do you have any health problem? …….. Yes
2. Are you under care of physicians? …….. Yes
   If yes, since when and why? ……..

3. Name of physician? _____
4. Are you receiving any medication? …… Yes No
   What? ……
5. Are you allergic to penicillin, antibiotics or other drugs? …….. Yes No
6. Are you allergic or sensitive to any metals or latex? …… Yes No
7. Do you have other allergies? …… Yes No
8. Have you had any serious illness? …… Yes No
   When…….. What? ……
9. Have you ever had surgery? …… Yes No
10. Do you have a heart murmur? …… Yes No
11. Is surgery contemplated? …… Yes No
12. Do you experience severe or prorogated bleeding? …… Yes No
13. Do you have AIDS or has he/she tested HIV positive? …… Yes No
14. Have you ever tested positive for hepatitis? …… Yes No
15. Are you subject to nervous disorders? …… Yes No
    - ❑ Fainting?
    - ❑ Seizures?
    - ❑ Dizziness?
    - ❑ Behavioral/Learning Problem?

16. Do you have frequent headaches? …… Yes No
17. Have you had history of: (Circle appropriate responses)
    diabetes, heart trouble, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight problems, cancer, infections, speech impairments, hearing loss.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Patient's / Guardian's signature _____ Date _____

Dentist's signature _____ Date _____