"WIC Smiles 4 U" WIC program: _____

DENTAL HEALTH RECORD Contact:: _____

Name: _____ Sex (M/F)___ Race:__B__W__H__O
(Last, First, Middle)

Home Address: _____
Street City State Zip Code

Date of Birth: ___/___/___ Home Phone # (___)_____ Other Phone # (___)_____

Doctor's Name: _____ Phone #:_____

Date of Last Medical Examination: ____/____/____ Reason:_____

Are you?
Under doctor's care now ___Yes ___No
Taking any Medication ___Yes ___No

Are you ALLERGIC TO?
Penicillin ___Yes ___No
Local Anesthetics ___Yes ___No
Medicines ___Yes ___No
Other Allergies ___Yes ___No

Do you receive MEDICAID? ___Yes ___No Medicaid#_____ SS#_____

Are you currently under the care of a private dentist? _____Yes _____No
Dentist's Name:_____ Address:_____ Phone#:_____
Does you have dental insurance? ___Yes ___No
Name of Insurance company:_____ Policy:_____

HAVE YOU EVER HAD?

Rheumatic Fever	___Yes ___No	Heart Trouble	___Yes ___No
Diabetes	___Yes ___No	Hepatitis, Jaundice or Liver Disease	___Yes ___No
Epilepsy	___Yes ___No	Anemia or Blood Disorder	___Yes ___No
Fainting Spells	___Yes ___No	High or Low Blood Pressure	___Yes ___No
Cortisone Therapy	___Yes ___No	Excessive bleeding from a cut or tooth extraction	___Yes ___No
Tuberculosis	___Yes ___No		
Kidney Trouble	___Yes ___No	Serious illness in the past	___Yes ___No
Asthma	___Yes ___No	Other Childhood diseases	___Yes ___No
Stomach Ulcers	___Yes ___No	Specify:_____	
Thyroid trouble	___Yes ___No		

Any other pertinent information concerning your health that we should be aware of?

Specify:_____

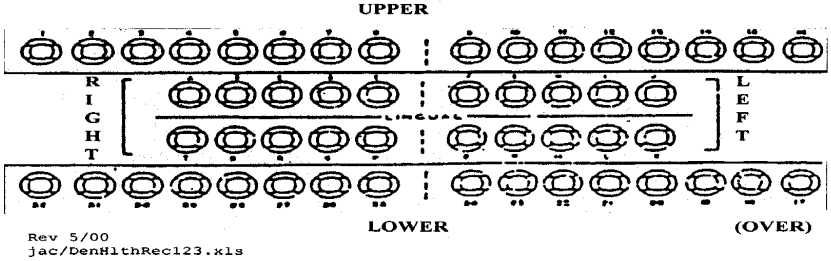
To the best of my knowledge, the above information is correct. I give my permission for dental treatment including, but not limited to, fillings, fluoride varnish, sealants, crowns, pulp treatments, extractions, emergency treatment for relief of pain/infection, and for diagnostic x-rays to be taken in the course of treatment.

X_____ _____
Patient or Parent/Guardian Signature Date

I have received a copy of the Health Insurance Portability Accountability Act (HIPAA) Law with this Dental Health Record.

X_____ _____
Patient or Parent/Guardian Signature Date

THIS SECTION TO BE COMPLETED BY THE DENTIST



DIAGNOSTIC CODE
SOLID ARE INDICATES FILLING PRESENT
ZEBRAS STRIPES INDICATE DECAY PRESENT
VERTICLE LINE INDICATES TO BE EXTRACTED
"X" INDICATES MISSING TOOTH

Rev 5/00
jac/DenHlthRec123.xls

Outline treatment given in the space below giving approximate cost for each service.
As each service is provided, please enter month, day and year in the appropriate section.

For Administration Use Only

SERVICES (PLEASE RECORD EACH TREATMENT ON A SEPARATE LINE)

Patient Last Name:_____ First Name:_____

Month	Day	Year	Tooth	Surface	Material	Description of Work	Fee	Code

***TREATMENT CODE:** **Total**

Surfaces: M – Mesial D – Distal O – Occlusal L – lingual B – Buccal or Labial

Materials: A - Amalgam S - Silicate P - Acrylic C - Steel Crown O - other_____

IMPORTANT:

- ☐ **Check if Treatment continued on additional record.**
- ☐ **Check if all work for the child has been completed.**
- ☐ **Check if Treatment discontinued.**

Remarks:_____

_____

Parent was present during examination. Yes__No__

Dentist discussed finding and recommendations with parent Yes__ No___

Dentist's Signature **Office Address** **Zip Code**

Dentist's License No. _____ **Telephone No. _____**

Dental services provided to Medicaid eligible enrollees will be billed to Medicaid. The Hillsborough County Health Department, Community Dental Health Program, will pay for Non-Medicaid dental services as agreed upon in the Memorandum of Agreement with Tampa Family Health Center. This Dental Health Record will be kept on file with Tampa Health Center.