Home: Own ___ Rent ___ Buying ___ Give Monthly Amount $_____

Family Dentist _____

Family Physician _____

Circle Yes or No

Is the patient covered by dental insurance? **Yes** **No**

Is the patient covered by medical card? **Yes** **No**

Can you supply transportation to the clinic? **Yes** **No**

Give Name, Grade, and date of birth for all Children at Home:

_____

_____

_____

_____

MEDICAL HISTORY: IF ANY of the following are circled yes, the patient's physician must sign where indicated on the back of this application.

Has the patient ever become sick from, shown allergy to, or been told not to take:

Circle Yes or No

Yes **No** Antibiotic(if yes, which one) _____

Yes **No** Novocain or other dental anesthetics _____

Yes **No** Other drug or medicine _____

Has the patient ever had any of the following:

Yes **No** Heart Disease, heart attack, heart murmur.

Yes **No** Shortness of breath without exercising or lying down.

Yes **No** Swelling of ankles or feet.

Yes **No** Pain, pressure, or tight feeling in chest.

Yes **No** Rheumatic fever **Yes** **No** Jaundice

Yes **No** Fainting spells, convulsions, epilepsy.

Yes **No** Nervous breakdown, psychotherapy.

Yes **No** Lung trouble (TB, asthma, emphysema)

Yes **No** HIV/AIDS **Yes** **No** Hepatitis, liver disease

Yes **No** Arthritis, sore joints.

Yes **No** Respiratory/Asthma Problems.

Yes **No** Radium or Cobalt treatments

Yes **No** Excessive bleeding following injuries or dental treatment

Yes **No** Diabetes, kidney disease

Yes **No** Blood trouble, anemia, leukmia

Yes **No** Cancer **Yes** **No** Osteoporosis

Yes **No** Artificial Joints **Yes** **No** Latex Allergies

Yes **No** Tobacco User

Is the patient:

Yes **No** Pregnant

Yes **No** Now being treated by a physician? If yes, for what?

Yes **No** Taking any medication? If yes, for what?

Service Recipients- Please check appropriate information.

White/Caucasian__ Black/African Am.__ Hispanic__ Asian __ Mixed __

Other:_____

Additional Information:

_____

_____

_____

Water Supply: City Well Cistern

Signature below indicates: Permission for any necessary dental work to be done. The information contained is true and to the best of your knowledge. All dental services will be performed at the Putnam Co. Dental Clinic located in Putnam Career and Tech Center, Eleanor, West Virginia.

Signature_____

This program is funded by United Way.

Live United

(Clinic Use Only)

I have examined this application and this patient is eligible for treatment in the clinic.

Comments: _____

_____

_____

_____

_____

Date: _____

Updated: _____

Updated: _____

I have given this patient a medical examination and he/she (is) (is not) approved for dental treatment.

Pre-medication with _____ is necessary.

Comments: _____

_____

_____

_____

_____

Date Physician

Putnam County Dental Health Clinic, Inc.

Application for Free Dental Treatment

Date: _____ New: _____ Renewal: _____

Putnam Career & Technical Center

100 Roosevelt Boulevard, Eleanor, West Virginia 25070, 304-586-3111

IF THE PATIENT HAS A PRIVATE DENTIST, MEDICAL CARD CHIPS, OR DENTAL INSURANCE, DO NOT FILL OUT THIS FORM

Parent or Guardian- please read carefully, give all information asked for, sign and return application to your child's school office immediately. If your child is eligible to be treated, an appointment will either be arranged by the clinic or you may call the clinic.

Patient's Name _____ Date of Birth _____

Patient's Social Security Number _____ Male Female

Address _____ Telephone _____

City _____ Zip _____

Name of Employer _____

Employer's Address _____

IF STUDENT: School _____ Grade _____

Husband/Father's Name _____ Income per Month $ _____

Name of Employer _____ Work Phone _____

Employer's Address _____

SS # _____ Date of Birth _____

Wife/Mother's Name _____ Income/Month $ _____

Name of Employer _____ Work Phone _____

SS# _____ Date of Birth _____

SS Income/Month $ _____ Unemployment $ _____ Other (Specify) $ _____