FLORIDA DEPARTMENT OF HEALTH IN PUTNAM COUNTY DENTAL CLINIC

Patient Information Form

Client Information

Patient Name: _____ Date of Birth: _____/_____/_____

Mailing Address: _____ City: _____ Zip: 32_____

Alternate Address: _____ City: _____ Zip: 32_____

Phone Number: (_____) _____-_____ Alternate number: (_____) _____-_____

Pharmacy: _____ Pharmacy number:(_____) _____-_____

Last Dental Appointment: _____/_____/_____ Name of Dentist: _____

Insurance Information

Dental Insurance Provider: (Please Circle) Liberty DentaQuest MCNA Self Pay: _____ %

Dental Emergency Visit Questionnaire

What is your current problem? (Please Circle) Swelling Fever Pimple in mouth OR Gum

Are you experiencing severe pain? (Please circle) Yes or No

Type of pain: (Please circle) Sharp Dull Continuous Throbbing ; if other please explain: _____

When did pain begin: ___/___/____ Does pain wake you up at night? (Please circle) YES NO

Are you taking any medications for this issue: (Please Circle) YES NO

If yes, please list; _____

Parent/Guardian Information

Is the legal parent/guardian here with the patient today? (Please circle) YES NO

Name of person with patient: _____ Relationship to patient: _____

Legal Parent/Guardian Name: _____ Signature: _____

By signing above, I attest that I am the legal parent/guardian of the client, and that the information provided is accurate and complete to the best of my knowledge.

Vital Signs: Office Use Only

Blood Pressure _____/_____ mmHG
Weight: _____lbs. _____oz
Temperature: _____°F

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