Georgia Department of Public Health
Chatham County
Health Department

Child's Name_____Date of Birth_____

Address_____Phone Number_____

Mother/Guardian Name_____Phone Number_____

Father/Guardian Name_____Phone Number_____

Emergency Contact Person_____Phone Number_____

Age_____Sex_____Race_____School_____

Primary Care Doctor_____Pharmacy_____

	YES	NO
Allergy to Drugs		
Allergy to Latex		
Allergies (Seasonal)		
Allergy to Food		
Allergy (other)		
Asthma		
Blood Disease		
Breathing Problem		
Cancer		
Diabetes		
Epilepsy		
Heart Disease		
Heart Murmur		
Heart Surgery		
Hepatitis A		
Hepatitis B or C		
Herpes		
High Blood Pressure		

	YES	NO
HIV or AIDS		
Inhaler for breathing		
Kidney Disease		
Liver Disease		
Prolonged Bleeding		
Psychiatric Problem		
Rheumatic Fever		
Seizures		
Severe Illness		
Sexually Transmitted Disease (S.T.D.)		
Sickle Cell Disease		
Sickle Cell Trait		
Surgery		
Thyroid Disease		
Tuberculosis		
Tumors		
Ulcers		

	Y	N
Do you have any questions or concerns about your child's teeth? If yes, please list		
Does your child have mouth or tooth pain? If yes, please list		
Has child ever been in the hospital or visited the emergency room? If yes, when and what for?		
Is child being treated by a doctor or having any medical tests? If yes, what for?		
Does child take any prescription medicine? If yes, please list		
Does child take any over the counter medications, supplements, or vitamins? If yes, please list		
Does child use tobacco, or Vape or Juul?		
Is child pregnant? If yes, when is due date:		

I consent to general dental treatment for my minor child or myself, which in the judgement of the dentist is necessary for oral health. This treatment may include but is not limited to the following: restoration of teeth, extracting of teeth, x-rays, administration of drugs/local anesthetics, root canals, periodontal treatment, prosthetics, oral surgery, cleaning, exam, fluoride treatments, sealants, and other specialty treatments deemed necessary. I approve the release of my records to my insurance/Medicaid or other health professionals as deemed necessary by the dentist. I authorize you to verify employment, financial or medical history, and other related matters as may be necessary to determine eligibility. I authorize the dentist to file claims and receive reimbursement directly from my insurance/Medicaid. I understand that this treatment request for dental treatment is valid for as many years as my child is eligible, by program policy, for this service. I have received the NOTICE OF PRIVACY POLICY for the Chatham County Board of Health. I authorize the use of any radiographs, photographs, and records for the purpose of teaching, research, referral to other healthcare providers and scientific publication. I further verify that the above medical history is true and accurate to the best of my knowledge. I have read and understood this information. I also understand that I have the right to ask questions about my child's care, and that I have the right to refuse any examination, treatment, or procedure.

*Date:*_____*Signature:*_____*Parent/Legal Guardian*