ELKS MOBILE DENTAL PROGRAM
Truman Medical Center Lakewood
7900 Lee's Summit Road, Kansas City, MO 64139
(816) 404-6904

I hereby consent and/or request the following named individual be provided dental care as indicated by the dental examination at:

Location: _____ Date: _____

Patient Name: _____ SSN: _____/_____/_____

Patient's Address: _____
Street City State Zip County

Birthdate: ___/___/___ Sex: ___ Race: ___ Medicaid No: _____

Medical Diagnosis: _____

Current Medication: Name _____ Dosage _____
Name _____ Dosage _____

Parent/Guardian: _____
Last Name, Father Mother

Parent's Address: _____
Street City State Zip

Telephone No: Home _____ Work _____
Other contact (to pass on message) _____

Was this patient ever seen by the Elks Unit at another location?
☐ Yes ☐ No If yes, where: _____

In the event that a health care worker is exposed to my blood or other bodily fluid capable of transferring pathogens, I consent to the drawing of my blood or other fluid for testing for HIV, hepatitis or other blood-borne pathogens. I understand that tests for HIV are not 100% accurate and sometimes produce both false positive and false negative results. I understand that positive test results must be reported to the Missouri Department of Health, and that confirmed HIV antibody test results may also be made available, in summary or statistical form, that do not include patient identification.

Signed: _____ Date: _____
Patient / Parent or Guardian

_____
Physician or Member of Medical Staff Signature Obtaining Consent

MEDICAL CLEARANCE FOR DENTAL TREATMENT ☐ Required (if checked)

Patient Name: _____ Diagnosis: _____
(Check Current Medications and dosages on form above)

Drug Sensitivities: _____

Medical problems complicating dental care: ☐ Yes ☐ No
Description: _____

_____

Recommended medication for dental treatment: _____

_____

The above named individual is cleared for dental treatment.

Signed: _____ MD / DO Date: _____

Dental / Medical History for: _____
(Patient Name)

Please answer the following questions concerning your health history or your child's (parent or guardian answer for children). Check yes, no or DK (don't know):

1. Are you/he/she under the care of a physician? ☐ Yes ☐ No ☐ DK
   If yes, please list the medical condition here: _____
   Name of your physician: _____
   Phone number: _____

2. Have you/he/she had any serious illness or operation or hospitalization in the past five years? If yes, please explain below. ☐ Yes ☐ No ☐ DK

3. Do you/he/she have now or have ever had any of the following diseases or problems:

   a. Rheumatic fever, heart murmur, St. Vitus Dance ☐ Yes ☐ No ☐ DK
   b. High blood pressure ☐ Yes ☐ No ☐ DK
   c. Heart trouble, Pacemaker ☐ Yes ☐ No ☐ DK
   d. Asthma, Hayfever ☐ Yes ☐ No ☐ DK
   e. Hepatitis, other liver disease, Jaundice or AIDS ☐ Yes ☐ No ☐ DK
   f. Venereal, social disease or bad blood ☐ Yes ☐ No ☐ DK
   g. Diabetes or sugar in your urine ☐ Yes ☐ No ☐ DK
   h. Kidney or Bladder trouble ☐ Yes ☐ No ☐ DK
   i. Tuberculosis or lung disease ☐ Yes ☐ No ☐ DK
   j. Fainting spells, seizures, epilepsy ☐ Yes ☐ No ☐ DK
   k. Anemia, Sickle Cell disease ☐ Yes ☐ No ☐ DK
   l. Arthritis or Rheumatism ☐ Yes ☐ No ☐ DK
   m. Hives, rash or other Allergies ☐ Yes ☐ No ☐ DK
   n. Breathing problems while upright or lying down ☐ Yes ☐ No ☐ DK

4. Have you/he/she had prolonged bleeding problems following a tooth extraction, surgery or injury? ☐ Yes ☐ No ☐ DK

5. After taking a drug, anesthetic or medicine by mouth, injection or skin application, have you/he/she ever had an unusual response or allergic reaction? ☐ Yes ☐ No ☐ DK
   If yes, please describe: _____

6. Have you/he/she ever had any unusual swelling, pain, or problems following dental treatment? ☐ Yes ☐ No ☐ DK

7. Have you/he/she had surgery or x-ray treatment (other than dental x-rays) within the past year? ☐ Yes ☐ No ☐ DK

8. Are you/he/she receiving anti-coagulant (blood thinner) therapy? ☐ Yes ☐ No ☐ DK

9. Do you/he/she have any condition/disease not listed above you think the dentist should know about? ☐ Yes ☐ No ☐ DK

10. Are you/she pregnant? ☐ Yes ☐ No ☐ DK
    If yes, how many months? _____

Reviewed by Dentist: _____ Date: _____

Problem List	Dental Management Considerations	Date