



# HOWARD COUNTY DENTISTS DELIVERING SMILES APPLICATION



Medicare:  Yes  No    Medicaid:  Yes  No    Health Insurance:  Yes  No  
 Dental Insurance:  Yes  No

Name: \_\_\_\_\_ Date of Application: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_ Township: \_\_\_\_\_

Telephone: \_\_\_\_\_ Age \_\_\_\_\_

Birth Date: \_\_\_\_\_

Social Security Number: \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone: \_\_\_\_\_

**Members of Household:**

Name	Relationship	Date of Birth
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Applicant's Place of Employment: \_\_\_\_\_

**Sources of income for household:**

\_\_\_\_\_ \$ \_\_\_\_\_  
 \_\_\_\_\_ \$ \_\_\_\_\_  
 \_\_\_\_\_ \$ \_\_\_\_\_  
 \_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_ (Total For Month)

**Additional Assistance:**

TANF: \_\_\_\_\_ HUD: \_\_\_\_\_ Trustee: \_\_\_\_\_  
 Food Stamps: \_\_\_\_\_ EAP: \_\_\_\_\_ Other: \_\_\_\_\_



Major Monthly Expenses:

Rent:	\$ _____	Child Care:	_____
Utilities:	\$ _____	Garnishment:	_____
Food:	\$ _____	Medical/RX:	_____
Child Support:	\$ _____	Other:	_____
Transportation:	\$ _____	Other:	_____

Additional information (if needed):

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Do you require wheelchair access? Yes No

Do you use a cane or a walker? Yes No

Name of last dentist seen: \_\_\_\_\_ Telephone: \_\_\_\_\_

Date of last visit: \_\_\_\_\_

How will you get to your dental appointment? \_\_\_\_\_

DENTAL QUESTIONS

Chief Complaint \_\_\_\_\_

In pain?  Yes  No  On & Off  Constant  Sharp  Dull  Throbbing

Sensitive to:  Hot  Cold  Sweets  Pressure  Chewing

Location:  Right side  Left side  Upper  Lower  Front  Back

Is there any swelling:  Yes  No What is swollen?  Gum  Face  Neck

Is a tooth Loose?  Yes  No Do they have a fever?  Yes  No

Any other information?

Application reviewed by: \_\_\_\_\_ (name)

money collected:

\_\_\_\_\_ (agency)

Yes

\_\_\_\_\_ (date)

No

Howard County Dentists Delivering Smiles

PatientName: \_\_\_\_\_

Do you have a Medical Doctor:            Yes            No

Physicians name and phone number: \_\_\_\_\_

Date of lastvisit: \_\_\_\_\_

Your current physical health is            EXCELLENT            GOOD            FAIR            POOR

Please Explain: \_\_\_\_\_

\_\_\_\_\_

Do you have or have you ever experience any of the following?

Please circle all that apply

- |                          |                         |                          |                          |
|--------------------------|-------------------------|--------------------------|--------------------------|
| Allergies                | Artificial Bones/Joints | Artificial Valves        | Arthritis                |
| AIDS/HIV                 | Blood Transfusion       | Cancer                   | Chemotherapy/Radiation   |
| Congenital Heart Defects | Diabetes                | Difficulty Breathing     | Emphysema/Asthma         |
| Drug/Alcohol Concerns    | Angina/Chest Pains      | Epilepsy/Seizures        | Fainting Spells          |
| Fever Blisters/Herpes    | Heart Attack            | Heart Murmur             | Heart Surgery/Pacemaker  |
| Hemophilia/Anemia        | Abnormal Bleeding       | Hepatitis/Liver Problems | High/Low Blood Pressure  |
| Kidney/Bladder Problems  | Latex Allergy           | Cosmetic Surgery         | Mitral Valve Prolapse    |
| Psychiatric Care         | Emotional Problems      | Rheumatic Fever          | Severe/Frequent Headache |
| Sinus Problems           | Stroke                  | Thyroid Disease          | Sexually Trans. Disease  |
| Ulcers/Colitis           | Other: _____            |                          |                          |

Are you taking any prescriptions or over the counter medications (Please list each one)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had problems with bleeding?    YES    NO

Have you had any adverse experience to Local Anesthesia? (Used for numbing)    YES    NO

Have you been advised to take Antibiotic Medication before any dental procedures    YES    NO

**For Women:** Are you pregnant    YES    NO    Week: \_\_\_\_\_

Are you nursing?            YES    NO            Taking Birth Control Pills?            YES    NO

**DENTISTS DELIVERY SMILES  
PATIENT RESPONSIBILITY AGREEMENT**

1. I agree to provide medical, dental, and financial information and documents upon request.
2. I give my permission to the dental coordinator to obtain information relative to my eligibility from appropriate physicians, dentists, individuals, and agencies.
3. I give my consent to the dental coordinator to release pertinent information to dentists to whom I am being referred.
4. I understand that I am not assured an examination nor that I will be accepted following an examination.
5. I understand that any dentist to whom I may be referred is not under any obligation to maintain me as a patient.
6. I understand that dental diagnosis and treatment of my dental problems is solely up to the dentists to whom I am being referred. I also understand that refusing to follow the physicians care plan may result in my dismissal from the program.
7. I agree to notify the dentist at least **twenty-four hours** in advance if I cannot keep an appointment. Failure to do so will disqualify me from the program.
8. I understand that I must conduct myself in an appropriate manner in the doctor's office. Failure to do so will disqualify me from the program.
9. I hereby release Dentists Delivering Smiles and any of its employees, associates or volunteers from any responsibility for changes in my health or well-being as a result of the care given.

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Patient Name

Date

Or

Minor, under 18 years

Physical/Mental Condition

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Spouse, Parent , Legal Guardian or Representative

Date

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Relationship

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Witness

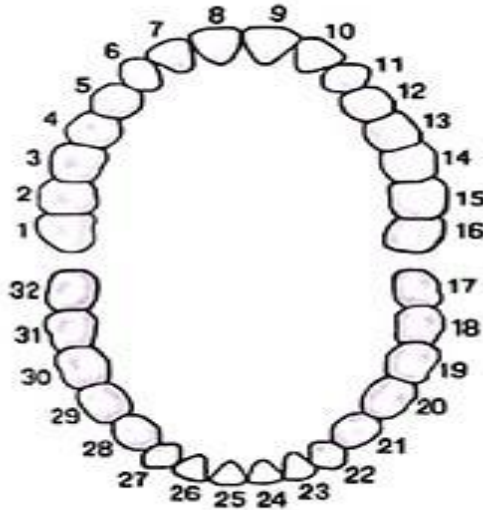
Date

**Upper Right:**

- 1: 3rd Molar (wisdom tooth)
- 2: 2nd Molar (12-year molar)
- 3: 1st Molar (6-year molar)
- 4: 2nd Bicuspid (2nd premolar)
- 5: 1st Bicuspid (1st premolar)
- 6: Cuspid (canine/eye tooth)
- 7: Lateral incisor
- 8: Central incisor

**Lower Right:**

- 25: Central incisor
- 26: Lateral incisor
- 27: Cuspid (canine/eye tooth)
- 28: 1st Bicuspid (1st premolar)
- 29: 2nd Bicuspid (2nd premolar)
- 30: 1st Molar (6-year molar)
- 31: 2nd Molar (12-year molar)
- 32: 3rd Molar (wisdom tooth)



**Upper Left:**

- 9: Central incisor
- 10: Lateral incisor
- 11: Cuspid (canine/eye tooth)
- 12: 1st Bicuspid (1st premolar)
- 13: 2nd Bicuspid (2nd premolar)
- 14: 1st Molar (6-year molar)
- 15: 2nd Molar (12-year molar)
- 16: 3rd Molar (wisdom tooth)

**Lower Left:**

- 17: 3rd Molar (wisdom tooth)
- 18: 2nd Molar (12-year molar)
- 19: 1st Molar (6-year molar)
- 20: 2nd Bicuspid (2nd premolar)
- 21: 1st Bicuspid (1st premolar)
- 22: Cuspid (canine/eye tooth)
- 23: Lateral incisor
- 24: Central incisor

Please Circle the Tooth/Teeth that are causing you pain and write a brief explanation of the symptoms including pain level.

In the box below please list the available times for appointments and good times to get ahold of you. Also any other notes that may affect your availability.

Monday

Tuesday

Wednesday

Thursday