COVENANT COMMUNITY CARE
"I WAS SICK AND YOU LOOKED AFTER ME" MATTHEW 25:36

Mobile Dental Team

After business hours for urgent care please call 313-554-3880 and follow the prompts.

PATIENT INFORMATION

Name		Date			Date of Birth	
Address	Apt #	City			State	Zip Code
Gender Identity		Social Security #			Medicaid #	
Cell Phone ( )		May we text this phone #	Yes	No	Parent's Name	
E-Mail Address						

HEALTH INFORMATION

Please check the boxes of all that apply.

AIDS/HIV		Diabetes		Head Injuries		Liver Disease		Sinus Problems	
Allergies		Dizziness		Heart Disease		Mental Disorder		Stomach Problems	
Anemia		Epilepsy		Heart Murmur		Pacemaker		Stroke	
Arthritis		Excessive Bleeding		Hepatitis		Pregnancy		Tuberculosis	
Artificial Joints		Fainting		Herpes		Due Date:		Tumors	
Asthma		Glaucoma		High Blood Pressure		Radiation Treatment		Ulcers	
Blood Disease		Growths		Jaundice		Respiratory Problems		Venereal Disease	
Cancer		Hay Fever		Kidney Disease		Rheumatic Fever			

List all medications: Include prescriptions, over the counter and herbal supplements you take routinely:

Are you allergic to any of the following: **List Other Allergies:**			Yes	No	Penicillin	Yes	No	Aspirin	
			Yes	No	Codeine	Yes	No	Dental Anesthetics	
			Yes	No	Sulfa Drugs	Yes	No	Clindamycin	
Height		Weight	Yes	No	Erythromycin	Yes	No	Latex	
Are you now under the care of a physician?			Yes	No	Date of last dental visit?	Purpose of visit?			

PRIVATE INSURANCE INFORMATION

Name of Insurance Plan:					Name of Insured:			Date of Birth:		
Patient's relationship to insured?	Self		Child		Is the patient insured?		Yes		No	
Subscriber/Policy #:					Group #:					

PATIENT HOUSEHOLD INFORMATION

Please check the boxes that describe your status. Covenant Community Care Family Dental Center is a non-profit public health facility.
The information below is vital for future funding of this clinic. Thank you for taking your time to complete this important information.

Explanation of Household Income	Number in Household:				Household Annual Income:							
Are you an US Veteran?	YES				NO							
What is your worker status?	Migrant Worker				Seasonal Worker							
What best describes your housing situation?	On Street		Shelter		Transitional Housing		Doubling Up		Other			
What languages are spoken in your home?	Spanish		English		Arabic		Sign Language		Other			
Gender Identity	Male		Female		Transgender Man – Female to Male		Transgender Woman – Male to Female		Other		Non-reporting	
Race	Native Hawaiian				Other Islander		Asian		Caucasian			
	Black/African American				American Indian		Hispanic/Latino		Other			

PERMISSION FOR DENTAL SERVICES: Covenant Community Care will provide these dental services: Exam, X-rays, Cleaning, Fluoride, Sealants, possible restorative care and a dental report card. **BY SIGNING THIS YOU ARE:** Authorizing and giving consent to allow Covenant Community Care to provide preventive dental treatment. Authorizing appropriate lab work be drawn should a health provider be exposed to health risk. Acknowledging you have received a Notice of Privacy Practices. Granting the authority to Covenant Community Care, Inc. the right to take photographs/ videos. Granting the authority to Covenant Community Care, Inc. to copyright, use and publish the same in print and /or electronically with or without your name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content. By signing this form, I am declaring that my household income is below the amount listed for my family size. **Agreeing to allow Covenant Community Family Dental Center to bill your insurance or Medicaid for reimbursement**. **If duplicate services are received during follow- up care obtained at your child's dental home, insurance benefits may be affected.**

Print Name: **Signature:** **(*Circle*) Patient or Parent/Guardian**

Please return this form to the SCHOOL OFFICE