PATIENT INFO and PROFILE

PATIENT INFORMATION Date: _____

Name: _____ DOB: _____

Address: _____ Phone: _____

_____ Medicaid #: _____

_____ SS#: _____

_____ _____

Print Name of Person Completing Form Relationship

LEGAL GUARDIAN

Name: _____ Phone: _____

Address: _____ Work Phone: _____

Relationship to patient: _____

DIRECT CARE AGENCY (if applicable)

Name: _____ Phone: _____

Address: _____

Medical Liaison: _____ Phone: _____

Case Manager: _____ Phone: _____

HOME BASED? Y/N **If Yes, Home Provider Name:** _____

PRIMARY PHYSICIAN

Name: _____ Phone: _____

Date of Last Exam: _____

PSYCHIATRIST

Name: _____ Phone: _____

1. **Please provide copy of current Medicaid Card.**
2. **Please provide copy of patient's current Therap Form and Health Passport, if applicable.**
3. **Please provide a copy of the patient's most recent Medical History and Physical, from physician.**
4. **If patient has private dental insurance, please provide copy of coverage and policy.**

Please Return completed form by mail to:

Carabelli Dental
824 N. Main St. Suite A
Roswell, NM 88201
Phone (575)-622-4455

PATIENT MEDICAL/LEGAL PROFILE

Height: _____ Hearing-Impaired: _____

Weight: _____ Visually Impaired: _____

Does this patient have meaningful speech? _____

Describe degree and nature of the disability and functional level of patient (Example: mental age, care needs, disability cause or diagnoses): _____

_____

Please list present medications, doses, and what medication is for:

_____

_____

Is patient allergic to, or had any adverse reaction to, any medications, foods, local anesthesia, or other item?

_____

_____

_____

Has patient been hospitalized in the last five years? _____ If yes, for what? _____

_____

_____

Describe any serious trouble the patient has had with previous dental treatment (including behavioral, aggression, sedation, bleeding, vomiting): _____

_____

_____

When was the patient's last dental treatment? _____

What was the appointment for? _____

Who was the last dentist seen? _____

Why did you leave their office? _____

Does the patient exhibit any oral habits? (finger sucking, hand biting, chewing objects, grinding of teeth, chewing on clothing, eating non-edibles, smoking, etc.) _____

_____

Who is responsible for brushing patient's teeth? _____ How often: _____

Is the patient on a special diet? _____ What kind: _____

Has the patient had a recent gain or loss of weight? _____

Does the patient have a feeding tube? _____ Does the patient need assistance with feeding: _____

Does the patient gag or throw up easily? _____

Describe the patients behavioral characteristics that disrupt this patient's life:

_____

_____

_____

(✓) any of the following that the patient presently has or has had in the past:

	Autistic Spectrum Disorder		Limited Joint Movement		Stomach Ulcers
	Seizures		Breathing Difficulties		Pneumonia
	Intellectual Disability		Heart Murmur		Depression
	Cerebral Palsy		Congenital Heart Disease		Obsessive Compulsive Disorder
	Hepatitis		Artificial Heart Valve		Schizophrenia
	Liver Disease		Heart Surgery		Post-Traumatic Stress Disorder
	Kidney Trouble		Heart Trouble		Organic Brain Disorder
	Diabetes		Shunt for fluid on the Brain		Attention Deficit Disorder
	Asthma		High or Low Blood Pressure		Tourette's Syndrome
	Hay Fever		Rheumatic Fever		Traumatic Brain Injury
	Thyroid Disease		Sores or Growth in the Mouth		Cancer
	Tuberculosis		Venereal Disease		Physical/Sexual Abuse
	Persistent Cough		Hemophilia		Artificial Joint
	Nasal Drainage		Anemia		Substance Abuse
	AIDS/HIV Virus		Cortisone Medication		Jaundice (yellow skin)

Please add any other information concerning the patient's medical or dental health we should know about:

STAFF ONLY

NOTES:

H.H Interview Information: