Dental Program Application

Full Name: ______________________________________ Date of Birth: ______________________

Last *First* *M.I.*

Address: ____

Street Address *Apartment/Unit #*

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City *State* *ZIP Code*

Phone Number: ________________________________ Email: __________________________________

Applicants must provide proof of residency in Louisa County and proof of all current income.

Household Number: _____________________________ Household Income: ________________________

Dental Issue: ____

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Have you seen a dentist for this issue? Yes No

If yes, please provide the dentist name and contact information: _____________________________

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Do you have dental insurance? Yes No

How has your dental health impacted your everyday life?

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Describe any previous dental care and/or treatment you have received in the past 5 years and where you have received it.

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Describe any current medical conditions and/or treatments you are receiving that may possibly affect your dental treatment.

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Name of Healthcare Provider(s): ____

Date of most recent physical examination: ________________________________

Do you have, or have you had, any of the following?

1. heart problems, or cardiac stent Yes No
2. history of infective endocarditis Yes No
3. artificial heart valve Yes No
4. pacemaker or implantable defibrillator Yes No
5. artificial heart valve or joints Yes No
6. rheumatic or scarlet fever Yes No
7. high or low blood pressure Yes No
8. a stroke Yes No
9. anemia or other blood disorder Yes No
10. prolonged or easy bleeding Yes No
11. COPD, emphysema Yes No
12. asthma, shortness of breath Yes No
13. breathing or sleep problems (i.e. sleep apnea, snoring) Yes No
14. kidney disease Yes No
15. liver disease or jaundice Yes No
16. thyroid, parathyroid disease, or calcium deficiency Yes No
17. high cholesterol or taking statin drugs Yes No
18. diabetes (HbA₁c = ____) Yes No
19. digestive disorders, reflux Yes No
20. neurologic disorders/epilepsy, seizures Yes No
21. viral infections and cold sores Yes No
22. any lumps or swelling in mouth Yes No
23. cancer treatment Yes No
24. more than 2 alcoholic drinks/day Yes No
25. illicit drug use Yes No

Do you, or have you, used tobacco (smoked or chewed) in the past 6 months? Yes No

List all medications, supplements, and/or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

Comments:

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I certify that my answers are true and complete to the best of my knowledge.

If this application leads to the receipt of services, I understand that false or misleading information in my application may result in denial of serves from Louisa County Resource Council.

Client's Signature: __________________________________ Date: ______________