**MUSKOGEE BRIDGES OUT OF POVERTY & CENTRAL BAPTIST CHURCH HEALTH CARE MINISTRY**

**DENTAL & DENTURE APPLICATION FORM**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ today’s Date \_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long at this address? \_\_\_\_\_\_\_\_\_\_ Church Affiliation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male\_\_\_\_\_ Female \_\_\_\_

Marital Status: Married\_\_\_\_\_\_ Divorced\_\_\_\_\_\_\_ Single\_\_\_\_\_\_\_\_ Separated\_\_\_\_\_\_\_\_ Widow\_\_\_\_\_\_\_\_

When was the last time you saw a dentist? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you had a jaw or facial injury? Y N Date \_\_\_\_\_

What dental or denture care do you need? Extractions \_\_\_\_ Deep Cleaning \_\_\_\_ New Dentures or Adjustment \_\_\_\_\_\_\_

 **Are you allergic to any of the following:** **Please list medications you are currently taking:**

 (Please circle **Y**=yes **N**=No) Medicine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y N Aspirin Medicine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y N Ibuprofen

Y N Sulfa Drugs Medicine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y N Penicillin

Y N Codeine Medicine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y N Latex, Metals

Y N Anesthetics Medicine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y N Other medications

 If so, which ones? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Do you have now or have you had any of the following?** (Please circle **Y**=Yes or **N**=No)

Y N Heart Disease Y N Liver Disease Y N Heart Murmur

Y N Congenital Heart Lesions Y N Jaundice Y N Hepatitis

Y N Diabetes Y N Rheumatic Fever Y N Excessive Urination or thirst

Y N Abnormal Blood Pressure Y N Herpes Y N Mononucleosis (Mono)

Y N Bleeding Disorder Y N Arthritis Y N Tuberculosis or Lung Disease

Y N Asthma Y N Hay Fever Y N Kidney Disease

Y N Sinus Trouble Y N Hearing Loss Y N Fainting Spells/Dizziness

Y N Cancer/Chemotherapy Y N Radiation Treatment Y N Tumor

Y N Ulcers Y N Drug Use/Addiction Y N Emotional or Nervous Disorders

Y N I smoke or use tobacco If yes, how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many years? \_\_\_\_\_\_\_\_\_\_\_\_

Have you had major surgery? Y N If yes, Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ Type of Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ Type of Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have consumed alcohol within the past 24 hours? Y N

**Women:** Are you taking birth control medications? Y N Are you (or could you be) pregnant or nursing: Y N

Do you have any other medical condition, medical problem or medical history not listed on this form? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

I am currently **actively participating** in Doorways of Hope or a local Celebrate Recovery Chapter: Yes\_\_\_\_\_\_ No \_\_\_\_\_\_

Or I am a **Bridges Out of Poverty Getting Ahead Investigator**: Current \_\_\_\_\_\_ or Graduated Date \_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OFFICE USE ONLY**: Today’s date \_\_\_\_\_\_\_\_\_\_\_ Interviewer’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Return visit needed? Y N If yes, date/time scheduled & reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Blood Pressure\_\_\_\_\_\_\_\_\_\_\_\_\_ Pulse\_\_\_\_\_\_\_\_\_\_\_\_\_ Resp.\_\_\_\_\_\_\_\_\_\_\_\_ Blood Glucose level\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Application reviewed by the Central Baptist Church Faith Community Nurse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_