Triax Dental (Michael D. Vaughan, DDS)

Medicaid Waiver Patient Intake Form

Version 2.2, Last update : October 3rd, 2019

triaxDENTAL

PATIENT INFORMATION

*Patient name:		*ISP effective date **(N/A if no ISP)**:	
*Social Security #:		*Date of birth (mm/dd/yyyy):	*Gender:
*Address:		*City:	*State: TN / *Zip:
*Ethnicity:	**This information is requested because Triax Dental LLC receives federal funding and therefore must establish a system for collecting and reporting data which shows the extent to which members of protected groups are participating in federally assisted programs and activities.		
*Home phone (or N/A):	*Mobile phone (or N/A):	*Patient height:	*Patient weight:
*Assistive Devices **(wheelchair, walker, etc. N/A if no devices)**:			
*Does the patient require a hoyer/mechanical lift for transfers? ☐ Yes ☐ No ☐ I don't know			
*Will the patient require Oral/IV Sedation for dental treatment? ☐ Yes ☐ No ☐ I don't know	Comments:		
*Reason(s) for referral and comments ☐ Pain ☐ Infection ☐ Inability to communicate pain	Additional information:		

CONTACT INFORMATION

*ISC Agency/Name **(N/A if no ISC)**:	E-mail:	Phone:
*Conservator **(N/A if no Conservator)**:	E-mail:	Phone:
*Responsible party for scheduling appointment:	E-mail:	*Phone:
*Pharmacy Name:	Fax:	Phone:
*Primary Care Physician:	Fax:	*Phone:

MEDICAL INFORMATION

*List all current diagnoses:	
*List all current medications (☐ **check here if no medications**):	
List all allergies (☐ **check here if no known allergies**):	Have you ever required antibiotics for dental treatment:

(please fill out the next page)

PLEASE ANSWER THE FOLLOWING QUESTIONS AND PROVIDE ANY RELEVANT INFORMATION

*Have you or any blood relative ever had a bad or unusual reaction to sedation or general anesthesia?	○ Yes ○ No
*Have you had any serious illnesses, accidents, operations or been hospitalized in the last 5 years? Please list:	○ Yes ○ No
*Have you ever had any of the following heart diseases or complications? **(Check all that apply)** ☐ *Prosthetic cardiac valves or valvular repair,* ☐ *Cardiac transplant,* ☐ *History of infective endocarditis,* ☐ *Unrepaired cyanotic congenital heart disease,* ☐ *Residual shunt or valvular regurgitation adjacent to prosthetic patch or device* **(If any apply, please provide documentation from a physician stating whether pre-medication is needed for dental procedures)**	○ Yes ○ No
*Have you ever had any of the following cardiovascular (heart) complications? **(Check all that apply)** ☐ *Chest pain or cyanosis upon exertion,* ☐ *Shortness of breath on exertion,* ☐ *High blood pressure,* ☐ *Stroke,* ☐ *Recurrent fainting,* ☐ *Myocardial infarction / heart attack*	○ Yes ○ No
*Have you been diagnosed with Sleep Apnea?	○ Yes ○ No
*Do you have any blood disorders such as Anemia or Sickle Cell Anemia?	○ Yes ○ No
*Do you have any pertinent health information not mentioned above? If yes, please explain.	○ Yes ○ No
Additional Comments:	
How did you find out about us?	

I understand that withholding any information about the patient's health could seriously jeopardize his/her safety. Therefore, I have reviewed the above medical health history carefully and have answered all questions truthfully and to the best of my knowledge.

For sedation appointments, I understand that the medication assessment record, annual physical exam, and health passport should be provided. I also understand that including an individual support plan can aid the treatment team in providing the best care for the patient.

Please type or sign your name (person filling out this form) _____ Date _____

Send completed form (* denotes required fields) by e-mail to records@triaxdental.com or fax (615) 915-6091