McLean County Health Department
Partners in Prevention

DENTAL CLINIC ** CLIENT INFORMATION

Today's Date _____ All Kids/Medicaid ____ Self Pay ____ Voucher ____

CLIENT INFORMATION: Please Print in Ink

Name _____, _____
Last Name First Name

Birth Date _____ Sex: Male O Female O

Address_____City_____ Zip Code _____

Address_____City_____ Zip Code _____

Primary Phone ( ) _____ Text Reminder for this number O Yes O No

Secondary Phone ( ) _____ Text Reminder for this number O Yes O No

May we have your permission to send emails about your appointments if necessary? O Yes O No

Email _____

Biological Parents Names: Mother (BIO) _____

Father (BIO) _____

Legal Guardian/Adoptive Parents Names _____

Relationship to Patient if Patient is under 18 years of age: O Legal Guardian O Adoptive Parent O Substitute Care Giver

O Step Parent name_____ O Caseworker name_____

If you are unable to accompany your child to the appointment, then a MCHD Permission/Proxy Form must be on file signed by a Biological parent, Adoptive parent or Legal Guardian (must have court documentation to prove guardianship/adoption) Before the appointment.

NOTE: Step Parents must be designated as a Proxy.

Please check the following if needed by Client or Parent: O Spanish Interpreter O French Interpreter O Hearing Impaired Interpreter

EMERGENCY CONTACT REQUIRED for Patients 18 years and over: In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

How did you hear about the Dental Clinic? Please Check: Friend____ Flyer____ DHS____ Denta Quest____
McLean County Health Dept. ____ Bus Advertisement____