Hagerstown Community College Patient Information Card

Patient

Name: First MI Last _____

Date of Birth: _____

Address: _____

_____

Cell Phone Number: _____

Home Phone Number: _____

Emergency Contact: _____

_____

(Name and Relationship)

Dentist of Record

Name: _____

Phone Number: _____

Fax Number: _____

Address: _____

_____

Physician

Name: _____

Phone Number: _____

Fax Number: _____

Address: _____

_____

Allergies to medication? YES NO

If yes, specify: _____

_____

History of Cancer? YES NO

Type: _____

Currently undergoing treatment? YES NO

IF YES, NO TREATMENT PERMITTED AT THIS TIME.

Student must obtain written confirmation from pt's MD to confirm or deny need for premedication , using the *Request for Medical Recommendation Form,* for all patients with conditions indicated for premedication according to the Premedication Update.

Date *RMR* sent: _____

Premed required for:

Joint replacement? YES NO

Heart Condition? YES NO

Other? YES NO

If other, specify: _____

Date:	Student: _____ DDS: _____
Date:	Student: _____ DDS: _____
Date:	Student: _____ DDS: _____

Date:	Student: _____ DDS: _____
Date:	Student: _____ DDS: _____
Date:	Student: _____ DDS: _____

Dental Health History		**Date of appt:**		**Student:**		
Date contacted:	Spoke to:	Last DOR exam:	Last Prophy: DDS HCC	Last FMX: DDS HCC	Last PAN: DDS HCC	Last BWX: DDS HCC

DOR authorized: BWX PAN FMX HCC DDS Signature:_______________________________________

Radiographs requested: ____________________________ Why: ____

Dental Health History		**Date of appt:**		**Student:**		
Date contacted:	Spoke to:	Last DOR exam:	Last Prophy: DDS HCC	Last FMX: DDS HCC	Last PAN: DDS HCC	Last BWX: DDS HCC

DOR authorized: BWX PAN FMX HCC DDS Signature:_______________________________________

Radiographs requested: ____________________________ Why: ____

Dental Health History		**Date of appt:**		**Student:**		
Date contacted:	Spoke to:	Last DOR exam:	Last Prophy: DDS HCC	Last FMX: DDS HCC	Last PAN: DDS HCC	Last BWX: DDS HCC

DOR authorized: BWX PAN FMX HCC DDS Signature:_______________________________________

Radiographs requested: ____________________________ Why: ____

Dental Health History		**Date of appt:**		**Student:**		
Date contacted:	Spoke to:	Last DOR exam:	Last Prophy: DDS HCC	Last FMX: DDS HCC	Last PAN: DDS HCC	Last BWX: DDS HCC

DOR authorized: BWX PAN FMX HCC DDS Signature:_______________________________________

Radiographs requested: ____________________________ Why: ____

Dental Health History		**Date of appt:**		**Student:**		
Date contacted:	Spoke to:	Last DOR exam:	Last Prophy: DDS HCC	Last FMX: DDS HCC	Last PAN: DDS HCC	Last BWX: DDS HCC

DOR authorized: BWX PAN FMX HCC DDS Signature:_______________________________________

Radiographs requested: ____________________________ Why: ____