HDC
Howard Dental Center
SAVING LIVES ONE SMILE AT A TIME

Referring Agency Name: _____

HEALTHCARE PROVIDER FORM

The purpose of this form is to show proof of eligibility. Make sure both you and your doctor sign the release at the bottom.

RE: _____ _____
Patient's Name — Healthcare Provider's Name

_____ _____
Patient's Address — Clinic/Hospital Name

_____ _____
City, State Zip Code — Clinic/Hospital Phone Number

Patient's Phone Number _____Date of Birth _____ Language _____

-This middle section to be filled by Healthcare Provider Only-

Please circle your answers:

Is Patient HIV positive?	YES	NO	Unknown
Does Patient have an AIDS diagnosis?	YES	NO	Unknown
Does Patient have Hepatitis?	YES A B C	NO	Unknown
Has Patient ever been tested for Tuberculosis?	YES	NO	Unknown
Does Patient have a history of Tuberculosis?	YES	NO	Unknown
Does Patient have any other infectious diseases?	YES	NO	Unknown

Current CD4 Count_____ **Current Viral Load** _____
Date of last medical appointment _____ **Date of last lab draw**_____
Drug Allergies _____ **Reaction**_____

Please list any other pertinent medical or psychological conditions (especially those that may require premedication).
_____
Are there any contra indications to having dental care/work completed on patient? If so, please describe.
_____

Please list all current medications or attach printed list _____
_____
_____

I, _____ (Patient Name), hereby authorize
_____ (Clinic Name) to release the above information to Howard Dental Center and also release them of all liability and claims of any nature pertaining to the disclosure of this information. I also authorize Howard Dental Center to contact my Health Care Providers in order to obtain information for optimum treatment and safety purposes.

_____ _____
Patient or Patient Representative — *Date*

_____ _____
Healthcare Provider's Signature — *Date*

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