

**ELKS MOBILE DENTAL PROGRAM**  
Truman Medical Center Lakewood  
7900 Lee's Summit Road, Kansas City, MO 64139  
(816) 404-6904

I hereby consent and/or request the following named individual be provided dental care as indicated by the dental examination at:

Location: \_\_\_\_\_ Date: \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ SSN: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient's Address: \_\_\_\_\_

Street City State Zip County  
Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \_\_\_\_ Race: \_\_\_\_ Medicaid No: \_\_\_\_\_

Medical Diagnosis: \_\_\_\_\_

Current Medication: Name \_\_\_\_\_ Dosage \_\_\_\_\_  
Name \_\_\_\_\_ Dosage \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Last Name, Father Mother

Parent's Address: \_\_\_\_\_

Street City State Zip

Telephone No: Home \_\_\_\_\_ Work \_\_\_\_\_  
Other contact (to pass on message) \_\_\_\_\_

Was this patient ever seen by the Elks Unit at another location?  
 Yes  No If yes, where: \_\_\_\_\_

*In the event that a health care worker is exposed to my blood or other bodily fluid capable of transferring pathogens, I consent to the drawing of my blood or other fluid for testing for HIV, hepatitis or other blood-borne pathogens. I understand that tests for HIV are not 100% accurate and sometimes produce both false positive and false negative results. I understand that positive test results must be reported to the Missouri Department of Health, and that confirmed HIV antibody test results may also be made available, in summary or statistical form, that do not include patient identification.*

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient / Parent or Guardian

\_\_\_\_\_  
Physician or Member of Medical Staff Signature Obtaining Consent

**MEDICAL CLEARANCE FOR DENTAL TREATMENT**  Required (if checked)

Patient Name: \_\_\_\_\_ Diagnosis: \_\_\_\_\_  
(Check Current Medications and dosages on form above)

Drug Sensitivities: \_\_\_\_\_

Medical problems complicating dental care:  Yes  No  
Description: \_\_\_\_\_

Recommended medication for dental treatment: \_\_\_\_\_

**The above named individual is cleared for dental treatment.**

Signed: \_\_\_\_\_ MD / DO Date: \_\_\_\_\_

