Health History

What is the reason for your visit to the dental clinic? _____
What is the name of your medical doctor? _____
What was the date of your last physical examination? _____
Has there been any change in your general health in this past year? _____
List any medication (pills or drugs) you are currently taking _____
List any Over-the-Counter medications or supplements you are taking _____

1. Do you have a toothache now? ..... Yes No
2. Have you received medical care in the past two years? ..... Yes No
3. Have you ever been hospitalized?.. Yes No
4. Have you taken medication (Prescription or Over-the-Counter) in the last two months? ..... Yes No
5. Are you allergic to or made sick by any medicine such as penicillin, aspirin, or codeine? ..... Yes No
6. Have you ever had a bleeding problem that needed medical treatment? ..... Yes No
7. Do you have chest pains? ..... Yes No
8. Do you use alcohol or other drugs? Yes No
   If yes, do you want to quit? ..... Yes No
9. Do you use tobacco products? ..... Yes No
   If yes, do you want to quit? ..... Yes No
10. Do you have reason to believe you have been exposed to AIDS or HIV? ..... Yes No
11. Do you have diabetes? ..... Yes No
12. Does anyone in your family have diabetes? If so, who_____ Yes No
13. Have you ever been treated for Osteoporosis or for a bone disease? ..... Yes No

Have you ever had the following?

14. Hepatitis..... Yes No
15. Heart Attack..... Yes No
16. High Blood Pressure..... Yes No
17. Infective Endocarditis..... Yes No
18. Congenital Heart Disease..... Yes No
19. Artificial Heart Valve or Pacemaker Yes No
20. Artificial Joint..... Yes No
21. Anemia..... Yes No
22. Stroke..... Yes No
23. Ulcers..... Yes No
24. TB or Lung Disease..... Yes No
25. Asthma..... Yes No
26. Sinus Trouble..... Yes No
27. Cancer or tumors..... Yes No
28. Epilepsy or seizures..... Yes No
29. Arthritis/rheumatism..... Yes No
30. Blood transfusions..... Yes No
31. Sexually Transmitted Diseases..... Yes No
32. Kidney Problems..... Yes No
33. Liver Problems..... Yes No
34. Nervous or mental disorders..... Yes No

Females Only

1. Are you pregnant? ..... Yes No
2. Taking birth control pills? ..... Yes No
3. Currently nursing? ..... Yes No

Do you have any disease, condition, or problem not listed? Yes No If yes, specify_____
Do you have any concerns about receiving dental treatment? Yes No If yes, specify_____

These answers I have given are true to the best of my knowledge, I am indicating my consent for routine dental procedures (examples: x-rays, cleanings, local anesthesia, etc.) by signing below

Patient or Parent/Legal Guardian:

_____

Patient Name: _____
Chart #: _____
DOB: _____
Today's Date: _____

Reviewed by: _____
_____
_____
_____

White Earth IHS Dental Outreach Program

The White Earth IHS Dental Clinic offers preventative dental care by collaborating with the local schools, preschools, daycares, and local Head Starts. Our goal is to help eliminate barriers to dental care for your child by bringing preventative dental care directly to them. It will also allow your child to miss less classroom time and will allow teachers to have a say in when your child should miss class, thus providing minimal disruption in your child's education. The dental program's focus will be on preventing decay in an attempt to prevent tooth pain and loss of teeth.

The services provided do not take the place of a regular dental check-ups and x-rays. This consent is for your child to receive services in the 2015-2016 Dental Outreach Program. Your child will be sent home with a letter that will briefly explain what was found and the urgency of need for your child's treatment.

If you would like your child to participate in the White Earth IHS Dental Outreach Program and get started with a visual screening and preventive care (cleaning, sealants, fluoride varnish, nutritional counseling, and oral hygiene instruction), please fill out the information below, **sign indicating your approval**, and send back to the school, Head Start, or daycare with your child. You will also need to fill out and return the attached **Mini Registration Form Update** and **Dental Health History Questionnaire**, which is required each year. If you are not interested in participating in this program, do not return this form.

Dental services/treatment to be received:

-Fluoride Varnish (strengthens teeth and prevents cavities)

-Visual Screening -Cleanings -Sealant

If at any time you have questions about your child's care or wish to discontinue your child's care with the Dental Outreach Program, please contact the main IHS dental clinic at 983-6285.

Child's Name_____ Date of Birth_____

School/Head Start/Daycare_____ Grade_____ Teacher_____

Has your child been seen for an exam since May 2014 at WHE, NTW, or PP dental clinics? Yes No

Does your child receive dental care at another dental clinic? Yes No

Is there any treatment you do **NOT** want us to provide to your child? Yes No

Please list: _____

Is your child eligible for services at White Earth Health Center? Yes No

_____ _____ _____

Parent/ Legal Guardian Printed Name Phone # Signature Date

For Administrative use only

Medical History_____ Mini Registration_____