



Chart #: _____

SMHWC Dental Patient Medical/Dental Health History and General Informed Consent Form

Name: _____ DOB: _____ City: _____ Tribe: _____ Phone: _____

If you are a non-native, are you a Stockbridge Munsee Tribal employee or are you married to a Stockbridge Munsee Tribal member? Yes____ No____

Do you carry dental insurance? Yes____ No____

What is the name of your medical doctor? _____

Has there been any change in your general health this past year? _____

If yes, please describe the changes: _____

List any medications (pills, drugs, injections, OTC medication, or herbs) that you have taken in the last two months:

List any known drug allergies you have: _____

Dental Information

For the following questions, mark (X) Yes, No, or Don't Know (DK).

	Yes	No	DK		Yes	No	DK
Do your gums bleed when you brush or floss?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or neck pains?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets, or pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does food or floss catch between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have sores or ulcers in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatments?...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontics?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in active recreational activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any problems associated with previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your home water supply fluoridated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you been advised to take antibiotics prior to dental treatment for any reason?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink bottled or filtered water?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam: _____			
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY				What was done at that time: _____			
Are you currently experiencing dental pain or discomfort?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of last dental x-rays: _____			

What is the reason for your dental visit today?

How do you feel about your smile?

*There is a backside to this form

Medical Information

For the following questions, mark (X) Yes, No, or Don't Know (DK).

	Yes	No	DK		Yes	No	DK
Have you had any serious illness or operation?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If so, what was the illness or operations? _____				Cancer or Leukemia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____				AIDS or other immunosuppressive disorders.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have, or have you had any of the following diseases or problems?				Hepatitis Exposure.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged heart valves or artificial heart valves, including murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had abnormal bleeding associated with previous extractions, surgery, or trauma?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you bruise easily?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular disease, heart trouble, heart attack, coronary insufficiency.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever required a blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure, arteriosclerosis, coronary occlusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If so, explain the circumstances:_____			
Do you have a cardiac pacemaker?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any blood disorders, such as anemia, sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever have chest pains?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you consume alcohol, smoke tobacco, use smokeless tobacco, or use marijuana regularly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus troubles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use or have you used an E-cig or vaporizer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma or hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever used drugs, cocaine, prescription drugs..etc. for recreation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COPD.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had surgery, x-ray or drug treatment for a tumor, growth, or other conditions of your head or neck?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hives or skin rash.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you taking or have you taken any medications for osteoporosis or Paget's disease? Examples include: alendronate (Fosamax), risedronate (Actonel), and denosumab(Prolia).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fainting spells, seizures, or epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Since 2001 were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates(Aredia or Zometa) for bone pain, hypercalcemia, or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any disease or illness not listed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have to urinate more than six times a day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, list here: _____			
Are you often thirsty?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Does your mouth frequently become dry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Hepatitis, jaundice or liver disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Arthritis or inflammatory rheumatism (painful swollen joints)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Artificial Joint.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Osteoporosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Stomach ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Kidney trouble/Dialysis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Do you have a persistent cough, or cough up blood?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Low blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Sexually Transmitted Diseases.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Psychiatric problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Women

Are you pregnant?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking birth control?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently nursing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IMPORTANT

The answers I have given are true to the best of my knowledge. I am indicating my consent for routine dental procedures such as x-rays, cleaning, fillings and local anesthesia by signing below.

Patient, parent or Guardian Signature _____ Date _____

Relationship to Patient _____

Provider Signature _____ Date _____