PERSONAL INFORMATION

TODAY'S DATE: _____

Name:_____ ❑ M ❑ F Date of Birth:_____ Age:_____

Preferred Phone number regarding Dental appointments: _____

Name for phone: _____

Email: _____

Dental Coverage: (Other than IHS) **We will need a copy of your insurance card.*

❑ Medical Assistance from the State of Minnesota:

Type _____ # _____

❑ Employer Sponsored Dental Insurance:

Insurance Company _____ Employer _____

Subscriber (Employee) Name _____

Subscriber (Employee) Date of Birth _____

ID # _____ Group # _____

Is this family coverage: Y❑ N❑

❑ No Medical Assistance or Dental Insurance

Emergency Information:

Emergency Contact Name and Relationship: _____

Emergency Contact Number: _____

MEDICAL HISTORY

Name: _____ **Date of Birth:** _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Physician's Name: _____ **Clinic:** _____
Last Date/Time you saw a physician: _____

Are you under the care of a physician?	❑Yes	❑No	Reason: _____
Have you ever been hospitalized or had a major operation?	❑Yes	❑No	Reason: _____
Have you ever had a serious head or neck injury?	❑Yes	❑No	Describe: _____
Do you have an artificial limb, joint, pins, plates or screws?	❑Yes	❑No	Describe: _____
Do you drink more than 2 cans of pop each day?	❑Yes	❑No	
Do you Smoke or Chew tobacco?	❑Yes	❑No	Amount: _____ Years:_____
Are you interested in quitting/smoking cessation?	❑Yes	❑No	

Where is your home water supply from? ❑Well ❑City ❑Don't Know
If Well Water, has your water been tested for fluoride? ❑Yes ❑No
Do you use a fluoride supplement? ❑None ❑Drops/Tablets ❑Fluoride vitamins ❑ Prescription Toothpaste ❑Rinses

Are you allergic to any of the following?
❑**NO ALLERGIES** ❑Penicillin ❑Clindamycin ❑Amoxicillin ❑Flagyl ❑Sulfa Drugs ❑Other Antibiotics ❑Aspirin ❑Codeine
❑Food ❑Metal ❑Latex ❑Local Anesthetics ❑Seasonal Allergies ❑Other:_____

Women: Are you?
Pregnant/Trying to get pregnant? ❑Yes ❑No Nursing? ❑Yes ❑No Using Oral Contraceptives/Norplant Implants? ❑Yes ❑No

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

Heart/Vascular Conditions:
- ❑ Artificial Heart Valve
- ❑ Infective Endocarditis
- ❑ Congenital Heart Defect
- ❑ Heart Disease
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Irregular Heartbeat
- ❑ Open Heart Surgery
- ❑ Heart Stent
- ❑ Mitral Valve Prolapse
- ❑ Pacemaker
- ❑ Rheumatic Fever
- ❑ High Blood Pressure
- ❑ Angina (Chest Pain)
- ❑ Stroke
- ❑ Blood Transfusions
- ❑ Abnormal Bleeding

Liver Conditions:
- ❑ Liver Disease
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hepatitis C

Lung Conditions:
- ❑ Asthma
- ❑ Breathing Problems
- ❑ Shortness of Breath
- ❑ Tuberculosis
- ❑ Emphysema

Kidney Conditions:
- ❑ Kidney Disease
- ❑ Renal Dialysis

Other Conditions:
- ❑ Diabetes
- ❑ Hearing Loss
- ❑ Organ Transplant:

Other Conditions, cont:
- ❑ AIDS or HIV positive
- ❑ Sinus Trouble
- ❑ Thyroid Disease
- ❑ Epilepsy/Seizures
- ❑ Arthritis
- ❑ Fibromyalgia
- ❑ Osteoporosis/Osteopenia
- ❑ Mental Health Care
- ❑Alzheimer's Disease
- ❑ Dementia
- ❑ Cancer:_____
- ❑ Leukemia
- ❑ Radiation treatment
- ❑ Chemotherapy
- ❑ Acid Reflux
- ❑ Stomach Ulcers
- ❑ MRSA
- ❑ Condition not listed:

Other Conditions, cont:
- ❑ Lupus
- ❑ Sjogren's Syndrome
- ❑ Other Autoimmune disease:_____
- ❑ Glaucoma
- ❑ ADD/ADHD
- ❑ Chemical Dependency

Dental Conditions:
- ❑ Bleeding Gums
- ❑ Mouth Sores
- ❑ Loose Teeth
- ❑ Broken Teeth
- ❑ Injury to Head, Neck or Jaw
- ❑ Difficulty Opening or closing
- ❑ Pain in Jaw Joints

I acknowledge that all the above information is accurate to the best of my knowledge. I hereby authorize MinNoAyaWin Dental Clinic and/or their trained staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my treatment needs. I also authorize MinNoAyaWin Dental Clinic and/or their trained staff to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents will be used when indicated and that this embodies certain risk. I hereby give my permission to release health information obtained from me, and information about my dental treatment to third party payers, and/or other health practitioners. I give MinNoAyaWin Dental Clinic permission to bill my insurance carrier and receive direct payment.

_____ _____ _____
Signature- legal guardian, if minor **Date** **Dentist Signature**

MEDICATIONS **Name: _____ Date of Birth: _____**

Do you receive all your medications from MNAW or CAIR pharmacy? ❑Yes ❑ No
If No, Where do you receive your medications from? _____

Please list all medications (prescription and over-the-counter) you are currently taking:

NAME OF MEDICATION	REASON FOR TAKING IT

- ❑ **I am not taking any prescription medications.**
- ❑ **I am not taking any over the counter medications. (Tylenol, Ibuprofen, Aspirin, etc.)**
- ❑ **I am not taking any vitamins or supplements.**
- ❑ **I cannot list all of my medications. Please view my medical record to obtain this information.**

(For Office Use Only:)

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Today's Date: _____