Bear Lake Community Health Centers

Bear Lake
325 West Logan Highway
Garden City, UT 84028
(435) 946-3660
(435) 946-8215 Fax

Cache Valley
1515 North 400 East
North Logan, UT 84341
(435) 755-6061
(435) 755-6091 Fax

Cache Valley South
26 West Main, Suite 3A
Hyrum, UT 84319
(435) 245-6988
(435) 245-6987 Fax

Evanston
75 Yellow Creek Road 102
Evanston, WY 82930
(307) 789-8290
(307) 789-8975 Fax

MEDICAL HISTORY

PATIENT NAME:_____ **DATE OF BIRTH:**_____
PHYSICIAN'S NAME:_____ **PHONE:**_____

PLEASE ANSWER ALL OF THE QUESTIONS YES OR NO AND PROVIDE ANSWERS WHERE APPLICABLE:

1.	Do you consider yourself to be in good health?	YES	NO
2.	Are you now or have you been under a physician's care within the past year?	YES	NO
	If Yes, specify condition being treated_____		
3.	Do you take any medications, including birth control pills?	YES	NO
	Please specify name and purpose of medications:_____		
4.	Do you have or have you ever had any heart or blood problems?	YES	NO
5.	Have you ever been told that you have a heart murmur?	YES	NO
6.	Do you require antibiotic pre-medication for a heart condition, artificial valve or artificial joint?	YES	NO
7.	Do you have or have you ever had high blood pressure?	YES	NO
8.	Do you bleed or bruise easily?.....	YES	NO
9.	Have you ever been diagnosed as being HIV positive or having AIDS?	YES	NO
10.	Have you ever had hepatitis or liver disease?	YES	NO
11.	Have you ever had: ☐ Rheumatic fever ☐ Asthma ☐ Any blood disorder ☐ Diabetes ☐ Rheumatism ☐ Arthritis ☐ Tuberculosis ☐ Venereal disease ☐ Heart attack ☐ Kidney disease ☐ Immune system disorder ☐ other disease If so, specify:_____	YES	NO
12.	Have you ever had an unusual reaction or are you allergic to any of the following drugs: ☐ Penicillin ☐ Aspirin ☐ Acetaminophen ☐ Ibuprofen ☐ Codeine ☐ Barbiturates ☐ Sulfa Drug ☐ Other If so, specify: _____	YES	NO
13.	Are you subject to fainting?	YES	NO
14.	Have you ever had a severe reaction to dental treatment or local anesthetics?	YES	NO
15.	Are you allergic to any local anesthetics?	YES	NO
16.	Do you have any other allergies? If Yes, please describe:_____	YES	NO
17.	Have you ever had a nervous breakdown or undergone psychiatric treatment?	YES	NO
18.	Have you ever received counseling for use of alcohol and/or prescription drugs?	YES	NO
19.	Women: Could you be pregnant?	YES	NO
20.	Are you now in pain?	YES	NO
21.	How long ago did you last see a dentist? _____		
22.	Who was your previous dentist? _____		
23.	Do you think that your teeth are affecting your general health in any way?	YES	NO
24.	Do you have or have you ever had bleeding or sensitive gums?	YES	NO
25.	Have you ever taken Phen-Fen or similar appetite suppressants?	YES	NO
	If Yes, have you seen you physician or cardiologist for a cardiac evaluation?	YES	NO
26.	Have you ever used or are you now using tobacco or alcohol?	YES	NO
27.	Have you ever taken Fosamax, Bonivia, or any other drugs for metastatic bone cancer?	YES	NO

I HEREBY CERTIFY THAT THE ANSWERS TO THE FOREGOING QUESTIONS ARE ACCURATE TO THE BEST OF MY ABILITY. SINCE A CHANGE IN MY MEDICAL CONDITION OR IN MEDICATIONS I TAKE CAN AFFECT DENTAL TREATMENT, I UNDERSTAND THE IMPORTANCE OF AND AGREE TO TAKE THE RESPONSIBILITY TO NOTIFY THE DENTIST OF ANY CHANGES AT ANY SUBSEQUENT APPOINTMENT.

Signature _____ **Date**_____
(Patient, legal guardian or authorized agent of patient)

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CONSENT TO PROCEED

I authorize Bear Lake Community Health Centers Dental Providers and/or such associates or assistants as she/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an adverse reaction or side effects, which may include, but not be limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely on occasion permanent numbness. I understand that occasionally needles break and may require surgical retrieval, and occasionally drops of local anesthetic may contact the eye and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment including preventive procedures such as, cleanings and basic dentistry, and fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of the treatment. Dental materials and medication may trigger allergic or sensitivity reactions as well.

After lengthy appointments jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue and cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases sutures or additional treatment may be required.

I understand that as part of the dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital, and in rare cases may require bronchoscope or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any; which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name: _____

Signature: _____ **Date:** _____

(patient, legal guardian or authorized agent of patient)

Witness: _____ **Date:** _____

(Rev. 4/14)