NORTHWEST MEDICAL TEAMS INTERNATIONAL, INC.

PATIENT HEALTH HISTORY
MOBILE DENTAL PROGRAM

Name of Patient_____ Birthdate_____ AGE_____ SEX M F

Address_____ City _____ State _____ Zip_____ Phone _____
Work Phone _____

Does your mouth or teeth hurt? _____ Where? _____

When was the last time you were seen by a dentist? _____ What was done? _____

Your physician's name? _____ Address _____ Phone _____

When were you last seen by your doctor? _____ Why? _____

Have you been hospitalized in the past two years? _____ Why? _____

Do you smoke? Y N How Much? _____ Are you pregnant? Y N Due Date: _____

Do you consume alcoholic beverages? Y N How much? _____

List **all** non-prescription medicine you are taking: _____

List **all** prescription drugs you are taking: _____

_____

Have you ever had an undesired reaction from a drug? _____ What drug? _____

Describe the reaction: _____

Do you bleed excessively when cut? _____

Do you now have, or have you ever had, any of the following: Circle Y (yes) or N (no) for each condition:

Y N	Abnormal Bleeding	Y N	Epilepsy	Y N	Hepatitis	Y N	Pacemaker
Y N	Anemia	Y N	Fainting Spells	Y N	High Blood Pressure	Y N	Respiratory Problems
Y N	Asthma	Y N	Glaucoma	Y N	HIV/AIDS	Y N	Rheumatic Fever
Y N	Cancer or Tumor	Y N	Hemophilia	Y N	Joint Replacement	Y N	Scarlet Fever
Y N	Chemotherapy	Y N	Heart condition	Y N	Kidney Disease	Y N	Tuberculosis
Y N	Chest Pain	Y N	Heart Surgery	Y N	Organ Implant	Y N	Ulcers
Y N	Convulsions	Y N	Heart Murmur – If yes, please check with your physician prior to dental appointment. Some heart murmurs require pre-medication for dental care.				
Y N	Diabetes						

This clinic is for low-income patients who have no private dental insurance or the means to pay for dental care at this time, and have a serious dental problem such as pain, an abscessed or broken tooth. (Oregon residents must not be on the Oregon Health Plan.) A licensed dentist(s) utilizing Northwest Medical Teams' Mobile Dental van will provide urgent care treatment.

I hereby request dental services and authorize the dentist(s) to perform the procedures that in his or her professional judgment are appropriate and necessary. This includes, but is not limited to, the administration of local anesthesia and/or nitrous oxide analgesia (laughing gas) and may include, if necessary, the extraction of baby or permanent teeth. Other treatment may include but is not limited to: sealants, silver fillings, tooth colored fillings, silver crowns, root canal therapy for baby or permanent teeth. If this consent is for a minor, I give permission for this care without my being present.

I understand that the dentist(s) providing the dental services is doing so without receiving payment directly from the patients being served. I understand and acknowledge that the dentist who will treat me is not controlled by nor affiliated in any manner with Regence BlueCross BlueShield of Oregon which organization has merely donated money to Northwest Medical Teams to purchase or operate a certain mobile dental van in which I may be treated.

_____ Date _____

Signature of Patient (or Guardian, if patient is under 18 years of age)