PATIENT HEALTH HISTORY
Dental Program

Operation Grace MN
Mobilizing Volunteers to Serve Others

Patient Name: _____ Birth date _____ Age _____
Address: _____ City _____ State _____ Zip_____
Sex: M F Height: _____ Weight: _____ Phone: Home _____ Work _____ Cell _____

Your physician's name: _____ Address _____ Phone _____
When were you last seen by your doctor? _____ Why? _____
Have you been hospitalized in the past two years? Y N If Yes, why? _____

When was the last time you were seen by a dentist? _____ What was done? _____
Does your mouth or teeth hurt now? Y N If Yes, where? _____

Do you smoke? Y N If Yes, how much? _____ Are you pregnant? Y N Due Date: _____
Do you consume alcoholic beverages? Y N If Yes, how much? _____
List all non-prescription medicine you are taking: _____
List all prescription drugs you are taking: _____
_____
Have you ever had a bad reaction to a drug? Y N If Yes, what drug? _____
Describe the reaction: _____

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

Y N Abnormal bleeding	Y N Chest Pain	Y N Heart disease	Y N HIV/AIDS
Y N Allergy to latex	Y N Convulsions	Y N History of Endocarditis	Y N Kidney disease
Y N Allergies in general	Y N Diabetes	Y N Heart surgery	Y N Organ implant
Y N Anemia	Y N Epilepsy	Y N Heart valve replacement	Y N Respiratory problem
Y N Anxiety attacks	Y N Excessive bleeding if cut	Y N Joint replacement	Y N Rheumatic Fever
Y N Asthma	Y N Fainting spells	Y N Pacemaker	Y N Scarlet Fever
Y N Cancer or tumor	Y N Glaucoma	Y N High blood pressure	Y N Tuberculosis
Y N Chemotherapy	Y N Hemophilia	Y N Hepatitis	Y N Ulcers

This Mobile Dental clinic is for low-income patients who have a serious dental problem (such as pain or an abscessed or broken tooth) and no private dental insurance or the financial means to pay for care at this time.

Licensed volunteer dentists utilizing the Operation Grace MN's Mobile Dental van(s) will provide treatment. In Minnesota, volunteer dentists' liability is limited; they may not be held liable for any injury, death, or other loss arising out of the provision of services unless the injury, death, or other loss results from gross negligence.

I understand that the dentist(s) providing the dental services is/are doing so without receiving payment directly from me, the patient. I understand and acknowledge that the dentist(s) providing treatment is/are under the supervision of Operation Grace MN and is/are not controlled by the organizations providing support to the Mobile Dental program.

I hereby accept these terms and authorize dental services and/or procedures that the dentist(s) in his or her professional judgment deems/deem appropriate and necessary. This includes, but is not limited to, the administration of local anesthesia and may include, if necessary, the extraction of primary or permanent teeth. Other treatment may include but is not limited to sealants, fillings (silver and white), stainless steel crowns, and root canal therapy for primary teeth.

I understand also that Operation Grace MN has not promised ongoing dental care for me and has not assumed responsibility for my ongoing dental care/treatment.

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

In addition, I have read and understand Operation Grace MN's *Notice of Privacy Practices*. **Initial if Yes**: _____