Are you having any pain or problems now? ____________________

When was you last cleaning? ____________________

When was your last dental treatment or x-rays?____________________

Dental Clinic/Dentist:____________________ When:__________

Do you have any of the following?

- Toothaches
- Bad Breath
- Bleeding Gums
- Cold Sores
- Periodontal/Gum Treatment
- Canker Sores
- Clenching/Grinding Teeth
- Clicking or Popping Jaw
- Jaw Locked Open or Closed
- Sensitive Teeth

Do you smoke or use tobacco? ____________________ How Often? __________

Do you put your child in bed with a bottle? YES/NO What is in it? ____________________

Do your children drink ONLY bottled water? ____________________

HOW DID YOU HEAR OF US?

- NACC Medical Provider Names:____________________
- Family or Friend
- Internet
- Insurance Company
- Agency? Which one____________________
- NACC Event? Which one____________________
- Other

Thank you for coming in to see us today!!!

NATIVE AMERICAN COMMUNITY CLINIC

Last Name | First Name | Middle Initial | Sex | Date of Birth

DO YOU HAVE or HAVE YOU EVER HAD THE FOLLOWING: CIRCLE

YES/NO		
Y	N	Heart Disease/Problems
Y	N	Heart Replacement
Y	N	Pacemaker
Y	N	Valve Damage/Replacement
Y	N	Rheumatic Fever w/ Heart Damage
Y	N	Stroke
Y	N	High Blood Pressure
Y	N	Low Blood Pressure
Y	N	Dizziness or Fainting
Y	N	Epilepsy or Seizures
Y	N	Diabetes
		o Oral Medications
		o Insulin
Y	N	Asthma or Respiratory Disease
Y	N	Ulcers or Stomach Disease
Y	N	Kidney or Bladder Trouble on Dialysis
Y	N	Thyroid Disease
Y	N	Tuberculosis/Positive TB Test
		Medications: ________________
		How long: ____________________
Y	N	Liver Disease
Y	N	Arthritis
Y	N	Artificial Joint
		Date Placed: _____/_____/_______

YES/ NO		
Y	N	Osteoporosis
		o Oral Medication
		o Injectable Medication
Y	N	Cancer or Tumor
Y	N	Radiation Treatment
		Where: __________________
Y	N	Hepatitis: A, B, C or Jaundice
Y	N	HIV or AIDS
Y	N	Sexually Transmitted Infections
Y	N	Persistent Cough/Cough up Blood
Y	N	Anxiety or Depression
Y	N	Psychiatric Treatment
Y	N	Head Injury
Y	N	Learning Disorder
Y	N	Alcohol or Drug Abuse/Addiction
		o Use in last 24 hours
Y	N	FAS/FAE
Y	N	Anemia
Y	N	Excessive Bleeding
Y	N	Frequent Sore Throat
Y	N	Shortness of Breath

Allergies: Latex, Seasonal, Medications
What medications are you allergic to:
____
Women are you Pregnant: Y N

Have you ever been hospitalized? Why? ____________________
Have you ever had excessive bleeding requiring treatment? ____________________
Any disease or condition not listed: ____________________

Primary Physician's Name or Clinic Name: ____________________
Address: ____________________

MEDICATIONS:____________________
____

SIGNATURE: ____________________ DATE: __________
(Parent/guardian if under 18)