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KAREN I. FRYBERG
TULALIP HEALTH CLINIC

Patient Information Form

FIRST NAME	M.I.	LAST NAME	TRIBE

GENDER	DATE OF BIRTH	SOCIAL SECURITY NUMBER

STREET ADDRESS	CITY	STATE	ZIP CODE

PHONE NUMBER	ALTERNATE PHONE NUMBER

MARITAL STATUS	SPOUSE

EMERGENCY CONTACT	PHONE NUMBER	RELATION

PRIMARY CARE PHYSICIAN	PHONE NUMBER

EMPLOYER	PHONE NUMBER

INSURANCE COVERAGE

INSURANCE TYPE ☐ DENTAL ☐ DSHS/PROVIDER ONE ☐ CHS (INDIAN HEALTH ONLY)		INSURANCE COMPANY
GROUP NUMBER	INSURANCE SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ PARENT	IF OTHER THAN SELF, SUBSCRIBER'S NAME*

* IF OTHER THAN SELF, ENTER SUBSCRIBER INFO. HERE ▶	DATE OF BIRTH	SOCIAL SECURITY NUMBER	EMPLOYER

CONSENT FOR MINOR'S TREATMENT

If you plan to send your child with someone other than a parent to a dental visit, you MUST list name and relationship of those (18 and older) that can accompany and make treatment decisions for this patient. **Must also have a current health history signed within the last 12 months by a parent/legal guardian.**

NAME	RELATIONSHIP
NAME	RELATIONSHIP
NAME	RELATIONSHIP
NAME	RELATIONSHIP

HEALTH HISTORY – PLEASE CHOOSE **YES** OR **NO** FOR THE FOLLOWING

☐ YES ☐ NO **AIDS**
☐ YES ☐ NO **ANEMIA**
☐ YES ☐ NO **ARTHRITIS**
☐ YES ☐ NO **ARTIFICIAL HEART VALVES**
☐ YES ☐ NO **ARTIFICIAL JOINTS**
☐ YES ☐ NO **ASTHMA** (LAST ATTACK: _____)
☐ YES ☐ NO **BACK PROBLEMS**
☐ YES ☐ NO **BLEEDING ABNORMALLY W/ EXTRACTIONS**
☐ YES ☐ NO **BLOOD DISEASE**
☐ YES ☐ NO **BLOOD THINNERS**
☐ YES ☐ NO **CANCER OR TUMOR** _____
☐ YES ☐ NO **CHEST PAINS** (WHEN: _____)
☐ YES ☐ NO **CONGENITAL HEART LESIONS**
☐ YES ☐ NO **PERSISTENT COUGH**
☐ YES ☐ NO **DIABETES** _____
☐ YES ☐ NO **EMPHYSEMA**
☐ YES ☐ NO **EPILEPSY** (LAST ATTACK: _____)
☐ YES ☐ NO **GLAUCOMA**
☐ YES ☐ NO **HEADACHES**
☐ YES ☐ NO **HEART MURMUR** _____
☐ YES ☐ NO **HEART ATTACK** (WHEN: _____)
☐ YES ☐ NO **HEART SURGERY** (WHEN: _____)
☐ YES ☐ NO **HEPATITIS** (TYPE: _____)
☐ YES ☐ NO **HERPES/COLD SORES**
☐ YES ☐ NO **HIGH BLOOD PRESSURE**
☐ YES ☐ NO **HIV POSITIVE**
☐ YES ☐ NO **JAUNDICE**
☐ YES ☐ NO **JAW PAIN/JAW JOINT PAIN**
☐ YES ☐ NO **KIDNEY DISEASE**
☐ YES ☐ NO **LIVER DISEASE**
☐ YES ☐ NO **LOW BLOOD PRESSURE**
☐ YES ☐ NO **MITRAL VALVE PROLAPSE**
☐ YES ☐ NO **NERVOUS PROBLEMS**
☐ YES ☐ NO **PACEMAKER**

☐ YES ☐ NO **STROKE** (WHEN: _____)
☐ YES ☐ NO **STREET DRUGS USED** _____
☐ YES ☐ NO **RESPIRATORY DISEASE**
☐ YES ☐ NO **RHEUMATIC FEVER**
☐ YES ☐ NO **SCARLET FEVER**
☐ YES ☐ NO **SHORTNESS OF BREATH**
☐ YES ☐ NO **SINUS TROUBLE**
☐ YES ☐ NO **SKIN RASH**
☐ YES ☐ NO **SPECIAL DIET** _____
☐ YES ☐ NO **SWELLING OF FEET/ANKLES**
☐ YES ☐ NO **SWOLLEN NECK GLANDS**
☐ YES ☐ NO **THYROID PROBLEMS**
☐ YES ☐ NO **SEXUALLY TRANSMITTED DISEASE**
☐ YES ☐ NO **TB/LUNG DISEASE**
☐ YES ☐ NO **TUMOR/GROWTH ON HEAD/NECK**
☐ YES ☐ NO **ULCER**
☐ YES ☐ NO **TAKING ASPIRIN**
☐ YES ☐ NO **UNEXPLAINED WEIGHT LOSS**
☐ YES ☐ NO **PREGNANT** (DUE: _____)
☐ YES ☐ NO **BIRTH CONTROL**

TAKING ANY MEDICATIONS? ☐ YES ☐ NO

ALLERGIES? ☐ YES ☐ NO

☐ LATEX ☐ ENVIRONMENT ☐ MEDICATIONS

TOBACCO USE? ☐ YES ☐ NO

WANT HELP QUITTING? ☐ YES ☐ NO

ANY OTHER MEDICAL CONDITION WE SHOULD KNOW?

_____

These answers are true to the best of my knowledge. I hereby give my informed consent to receive any dental treatment considered necessary including the use of anesthetic and medications as judged necessary by the dentist. I authorized the attending dentist to release any information required in the course of my examination to my insurance company, CHS, dental labs and referred specialists. I request payment to be made directly to the Tulalip Dental Clinic for any benefits due for all services rendered here at the Tulalip Dental Clinic.

DATE	PATIENT/PARENT/GUARDIAN SIGNATURE
DATE	ATTENDING PROVIDER

TDS-24516

Clear Form Print Form