



Adult Consent and Medical History

PATIENT INFORMATION

YOUR NAME: _____ DATE of BIRTH: _____
 STREET: _____ GENDER: Male or Female
 CITY: _____ ZIP: _____
 PHONE: _____ (Home) _____ (Cell or Work)
 In case of emergency, Contact Person: _____ Phone: _____

REFERRING AGENCY

Please check of which agency you are a patient.

DelValle Wellness El Buen Samaritano Clinic People's Community Clinic Volunteer Clinic H A A M
 Pflugerville RoundRock Clinic YMCA/RR Other: _____



MEDICAL HISTORY

Please complete to the best of your knowledge.

| | |
|--|---|
| Physician's Name: _____ | Date of last dental visit: _____ |
| Have you had any serious illnesses or operations? | If yes, what? _____ |
| Have you been a patient in a hospital in the last year? | (If female) Are you pregnant? _____ Trimester: _____ |
| Are you currently taking medications? Please list: _____ | Are you allergic to any drugs/medications? Please list: _____ |

Do you have or have you had any of the following conditions:

| | | | |
|---|---|--|---|
| <input type="checkbox"/> Latex Allergy <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Mitral valve prolapse <input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy/seizures <input type="checkbox"/> Heart Problems <input type="checkbox"/> Heart Surgery <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> HIV positive or AIDS <input type="checkbox"/> Joint Replacement <input type="checkbox"/> Kidney treatment <input type="checkbox"/> Lung problems <input type="checkbox"/> Organ transplant <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Radiation Treatment <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Sinus trouble <input type="checkbox"/> Stroke <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Ulcer <input type="checkbox"/> Venereal Disease |
|---|---|--|---|

CONSENT

Please sign and date below.

St. David's Dental Program is a dental clinic on wheels. It travels to agencies and schools around Austin to provide **FREE** dental care. If you receive treatment, please know that:

- If needed, we may provide an over-the-counter medicine such as Tylenol.
- Some dental work may be done using a local anesthetic. No nitrous oxide (laughing gas) or sedative drugs are used.
- Prescription drugs may occasionally be necessary. If so, these drugs are not given out on the van. If necessary, you will be given a written prescription to take to the pharmacy.

Signature X: _____ **Date:** _____

Your name (please print): _____

Please mark your race. This information will be kept private and will help with our data collection.

White Hispanic Black/African American American Indian/Native Alaskan
 Asian Multi-race Unknown Other _____

Record entered/updated by: _____