



Consent for Treatment

I authorize the Santa Fe Service Unit Dental Team to perform the clinical procedures necessary to treat pain, decay and / or infection present in my mouth. My dental condition has been explained to me and have discussed alternative treatment options (if available) with the Dental Team. I understand that a printed copy of my treatment plan is available upon request.

I understand that there are risks associated with any dental treatment(s). Also, I understand that it is common for my Dental Team to numb areas of my mouth so that treatments can be completed with minimal discomfort; and, that the risks from numbing may include discomfort, rapid pulse (fluttery heart beat), swelling, bleeding, bruising and /or lip biting.

My dentist has given me the opportunity to discuss these risks and all of my questions have been answered to my satisfaction. I understand that any treatment provided by my dental team is intended to help me and my teeth but that a perfect result cannot be guaranteed. I am aware of my right to decline treatment of any kind and I am aware of the possible consequences of non-treatment. My dentist will help me determine the best filling material (silver amalgam or white resin) to be used for my cavity, depending on my individual risk factors to ensure that my filling will last a long time.

I have disclosed my health history information, including allergies, reactions to medicine, diseases, and past procedures. I understand that withholding this information may affect the outcome of the treatment plan.

In the event of a medical emergency, I give my consent for these individuals to administer emergency medications and to perform any necessary life-saving procedures.

I have read and am in agreement with this Consent for Treatment. The Dentist and/or Dental Assistant have answered my questions to my satisfaction.

Patient/ Guardian Signature Date

Patient/ Guardian Signature Date

Patient Name:

Chart #:

DOB:

DEPARTMENT OF HEALTH AND HUMAN SERVICES Indian Health Service DENTAL PATIENT MEDICAL HISTORY

Patient Name: _____

Last Name
First Name
MI

Date of Birth: ____ - ____ - ____

Month
Day
Year

Please complete this form so that we can better provide care for your oral health needs.

What is the purpose of your visit to our office today? _____

Do you have a toothache now? Yes No If yes, for how long? _____

On a scale of 0-10, with 10 being the most painful, what is your pain level today? _____

How confident are you filling out medical forms by yourself? (Check one)
 Not at all A little bit Somewhat Quite a bit Extremely

If you are unsure of how to answer any of the questions, please ask the dental staff for help.

Please respond by circling the number that mostly closely answers	Not At All	Several Days	Over Half the Days	Nearly Every Day
Over the past 2 weeks, have you had little interest or pleasure in doing things?	0	1	2	3
Over the past 2 weeks, have you felt down, depressed, or hopeless?	0	1	2	3
Personal Safety				
Do you feel safe at home? <input type="checkbox"/> Yes <input type="checkbox"/> No Would you like to discuss your safety with a provider? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Have you ever had any of the following conditions?	Yes	No	Dates if known and short description	
Circulatory System				
Congenital heart disease, defect, or heart murmur?				
Heart disease or congestive heart failure?				
Heart attack?				
High blood pressure (hypertension)?				
Bacterial endocarditis?				
Chest pain or angina?				
Anemia or abnormal bruising or bleeding?				
Do you have a pacemaker, defibrillator, or other artificial heart device?				
Do you take blood thinners (e.g. Plavix, baby aspirin, Coumadin, warfarin)?				
Immune System				
Organ transplant or on organ transplant list?				
Spleen removed?				
Addison's or Cushing's disease, chronic steroid use (e.g. prednisone, etc.)				
HIV or AIDS, or do you believe you have been exposed?				
Lupus, rheumatoid arthritis, or any autoimmune condition?				
Irritable bowel syndrome, Crohn's disease, stomach ulcers, or gastric bypass?				
Cancer, tumors, chemotherapy, or radiation?				
Do you take medications that suppress your immune system (e.g. Remicade)?				
Excretory System				
Kidney problems, including dialysis?				
Hepatitis? If so, what type and is it currently active?				
Do you have any type of liver condition?				
Endocrine System				
Diabetes? If yes, what type?				
Thyroid problems of any kind? If yes, was it high or low thyroid?				
Do you take a thyroid medication (e.g. Synthroid, levothyroxine)?				
Nervous System				
Stroke?				
Epilepsy, seizures, multiple sclerosis or a nervous system disorder?				
Musculoskeletal System				
Osteoporosis or taken medicine for osteoporosis? Please list.				
Joint replacement (hip, knee, ankle, shoulder)?				
Osteoarthritis (i.e. degenerative arthritis)?				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
DENTAL PATIENT MEDICAL HISTORY

Patient Name: Last Name First Name MI

Date of Birth: Month Day Year

Table with columns: Yes, No, Dates if known and short description. Rows include: Respiratory System (Asthma, Tuberculosis), Reproductive System (STD), Substance Use (smoke, vape, etc.), and General Questions (physical disability, surgery, etc.).

Please list all medications you currently take (include over-the-counter drugs and herbal supplements):

Table with 4 columns: Medication Name, What is it for?, How often do you take it?, What dosage (mg, etc.)?

Date of last medical appointment? Purpose of that appointment?

Who is your primary care physician/provider?

Please carefully read the following statement and sign below.

The answers I have given above are true to the best of my knowledge. I am indicating my consent for routine diagnostic tests and procedures such as x-rays, cleaning, blood pressure, local anesthesia, fillings, crowns, and fluoride by signing below on behalf of myself or the above named minor in my guardianship.

Patient/Guardian Signature: Date/Time:

Provider Signature: Date/Time:

***** PROVIDER NOTES *****

Provider Name: Patient Health Record Number:

Notes:

Santa Fe Indian Hospital Dental Patient Agreement

Dear Patients: In order to provide the very best dental services, patients are scheduled for appointments.

Please carefully read the following:

Clinic hours are 8 AM to 5:00 PM: Appointments are scheduled Monday through Friday with the first appointment scheduled at 8 AM and the last appointment scheduled at 3:30PM. All routine care is provided after you have had your dental exam. **You should arrive 15 minutes** before your scheduled appointment to complete **patient registration** and necessary paperwork.

Cancelled Appointments: Please notify us 24-hours in advance if you are unable to keep your appointment. This enables us to better serve the community and to schedule other patients. Remember, the sooner you call the sooner we will reschedule your appointment. If you are sick or having any cold or flu symptoms, please call to reschedule your appointment.

Missing/Broken Appointments: If you are more than **10 minutes** late for your appointment it is considered a broken appointment and you may be reschedule if other patients are being treated in your place. If you have **3 consecutive broken appointments**, we cannot reschedule or make an appointment for the next 6 months.

No Specialty Dental Care: We are **not** able to provide specialty dental services. Specialty Dental Care includes root canals, crowns and bridges, dentures, partials and certain surgical procedures. We apologize for any inconvenience this may create.

Urgent Care/Emergency Treatment: Patients with urgent dental needs or tooth pain can call the dental clinic to schedule an appointment for urgent/ emergent dental treatment during clinic hours, Mon- Fri. Please note: Patients can no longer “walk-in” to the dental clinic without an appointment.

Treatment of Minors: A minor is defined as anyone under the age of 18 years. A parent/legal guardian or family member with written consent must accompany all minors for treatment. However, a parent or legal guardian must accompany the minor for the initial exam appointment and be present for any irreversible procedures such as removing a tooth.

Children in the Treatment Area: For safety and infection control reasons, if your child cannot sit still and needs your attention and there is no one to watch your child, then your appointment will be rescheduled.

Children in the Waiting Room: Please do not leave your child/children unattended. If you are unable to secure childcare, we will reschedule your appointment.

Intoxicated Patients: For your safety and the safety of the staff, intoxicated patients will be rescheduled.

I have read and am in agreement with this policy. The Dentist and/or Dental Assistant have answered my questions to my satisfaction.

Patient/Guardian Signature

Date

Dentist/Dental Asst. Signature

Date



Dear Parents and Legal Guardians of Santa Fe Indian School Students:

The Santa Fe Indian Health Service Dental Staff would like to provide routine dental care including x-rays, dental exam, sealant, cleaning, filling, and fluoride application for every Santa Fe Indian School student this year. In order to provide these routine services, we will need your written consent. **If you would like our staff to schedule a dental exam for your child at the Santa Fe Indian Hospital Dental Clinic for routine dental care**, please sign where indicated below and complete the attached Medical History Form.

With signed consent, these routine services may be provided without you having to be present. *Please note: if more specialized services need to be done, such as a tooth pulled (extraction) or a root canal, the parent or legal guardian will need to be present for those procedures.*

Student Name: _____ Grade: _____ DOB: _____ Chart #: _____

For ease of scheduling, please check one for your student:

____ Day Student ____ Dorm Student

Yes, I do give permission for my child to receive:

- X-rays and dental exam
- Sealants & Fluoride Varnish
- Cleaning
- Fillings
- Athletic Sportsguards

Yes, I give permission for my child, but ONLY for:

- Sealants & Fluoride Varnish

No, I do not wish for my child to receive any dental services at the Santa Fe Service Unit

Parent/ Legal Guardian Signature

Date

Telephone #