

Dental Foundation of Oregon – Tooth Tax Patient Information Form

THIS FORM IS 2-PAGES

Please fill out this form **completely**. If you have questions, please contact your school co-coordinator.

Patient's Legal Name _____		Birth Date (mm/dd/yyyy) _____	
Patient Nickname _____		Parent or Legal Guardian Name _____	
School Attending _____	Grade _____	Age _____	Sex (circle) M F
Home Address _____			
Street/ P.O. Box	City	State	Zip
Phone Numbers: Home (_____) _____		Work (_____) _____	
Cell (_____) _____			
Emergency Contact: Person to contact in case of an emergency			
Name _____		Relation to patient _____	
		Phone (_____) _____	
Ethnicity: Which one of these groups would you say best represents the patient's race? (circle one)			
<i>White</i>	<i>Hispanic</i>	<i>Black or African American</i>	<i>Asian</i>
		<i>American Indian</i>	<i>Other</i> _____
Income: Which of these best represents your annual household income? (circle one)			
<i>Less than \$10,000</i>	<i>\$10,000-20,000</i>	<i>\$20,000-30,000</i>	<i>More than \$30,000</i>
Household Size: How many children less than 21 years of age live in your household? _____			

Dental History	Yes	No	Please explain answers
Is this the patient's first dental visit?			
If no, how long has it been since the patient last saw a dentist?			
Does the patient have to travel more than 60 miles for dental appointments?			
Has the patient had any unpleasant experiences in a dental or medical office?			If "yes" please explain.
Does the patient brush daily?			If "yes" how often?
Does the patient floss?			If "yes", how often?
Does the patient drink soda pop or other sugar sweetened drinks daily (Kool-aid, fruit drink, Gatorade, sport drinks)?			How many does the patient drink per day?
Does the patient drink milk daily?			How many times per day?
Has dental pain caused you or your child to miss school and/or work in the past year?			If "yes", circle – school work both How many times?
Has the patient visited the ER hospital for dental pain in the last year?			How many times?

Reason for Visit: Check any that apply (✓)			
<input type="checkbox"/> First examination	<input type="checkbox"/> Accident to teeth	<input type="checkbox"/> Routine exam	<input type="checkbox"/> Other (specify) _____
<input type="checkbox"/> Toothache	<input type="checkbox"/> Bleeding around teeth	<input type="checkbox"/> Couldn't afford dental care	_____
<input type="checkbox"/> Mouth pain/face swelling	<input type="checkbox"/> Teeth Appearance	<input type="checkbox"/> Couldn't get appointment anywhere else	

THIS FORM IS 2-PAGES

Medical History

THIS FORM IS 2-PAGES

Patient's Current Physician _____ Past or Current Dentist _____

Medical History	Yes	No	Please Explain "yes" Answers
Does the patient have a current medical condition?			
Has the patient been diagnosed with autism?			
Is the patient taking any medications?			
Has the patient ever been hospitalized or had surgery?			
Does the patient have any allergies?			
Does the patient have any allergies to drugs?			
Is the patient currently protected by immunization (shots) against DPT (diphtheria, whooping cough, tetanus) polio, measles, mumps, and German Measles (rubella)?			
Does the patient smoke or use any type of tobacco products?			
Does the patient have any special needs that would require special arrangements for dental care?			

Has the patient had a history of or had difficulty with the following? Check any that apply (✓)

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Latex allergy | <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mono |
| <input type="checkbox"/> AIDS / HIV | <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Epilepsy/ seizures | <input type="checkbox"/> Bladder problems | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Birth defects | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Stomach/ intestinal disorders |
| <input type="checkbox"/> Chronic ear infections | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chronic eye infections | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Liver disease | |
| <input type="checkbox"/> Sore throats | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Measles | |

For x-ray purposes:
 Could the patient be pregnant?

Please explain "yes" answers: _____

Behavioral Issues	Please Explain "yes" answers
Anything about your child's behavior that we should know to help us provide dental care? ___Yes ___No	

Insurance: Do you have OHP dental coverage? ___Yes ___No ID# _____

CIRCLE your OHP Dental Plan and provide a copy of the letter that gives ID#, CCO & dental assignment:

Access Advantage Capitol Care Oregon Family Dental Managed Care ODS Willamette

Is your child covered with The Children's Program? ___Yes ___No ID# _____ (include copy of enrollment letter with ID#)

Do you have PRIVATE dental insurance? ___Yes ___No If yes, please complete the following and provide a copy of dental insurance card.

Dental Ins.Co. name: _____ Ins Co. address _____

Subscriber Name: _____ Subscriber Date of Birth: _____

ID# _____ Employer Name: _____ Group #: _____

 Parent/ Legal Guardian signature _____ Date _____

THIS FORM IS 2-PAGES