Dental Foundation of Oregon – Tooth Taxi
Patient Information Form

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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)

White *Hispanic* *Black or African American* *Asian* *American Indian* *Other*_____

Income: Which of these best represents your annual household income? (circle one)

Less than $10,000 *$10,000-20,000* *$20,000-30,000* *More than $30,000*

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 (√)

☐ First examination	☐ Accident to teeth	☐ Routine exam	☐ Other (specify)
☐ Toothache	☐ Bleeding around teeth	☐ Couldn't afford dental care	_____
☐ Mouth pain/face swelling	☐ Teeth Appearance	☐ Couldn't get appointment anywhere else	

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Medical History

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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 (√)

☐ Latex allergy	☐ Anemia	☐ Diabetes	☐ Mono
☐ AIDS / HIV	☐ Asthma	☐ Fainting	☐ Mumps
☐ Epilepsy/ seizures	☐ Bladder problems	☐ Hearing problems	☐ Rheumatic fever
☐ Excessive bleeding	☐ Birth defects	☐ Heart problems	☐ Stomach/ intestinal disorders
☐ Chronic ear infections	☐ Cancer	☐ Hepatitis	☐ Tuberculosis
☐ Chronic eye infections	☐ Cerebral Palsy	☐ Kidney disease	☐ Other _____
☐ Sinus problems	☐ Chicken pox	☐ Liver disease	**For x-ray purposes:**
☐ Sore throats	☐ Convulsions	☐ Measles	☐ **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 _____

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