Multnomah County
Health Department

Name: _____
MRN: _____
DOB: ____/____/____ ID#_____
Sex: M ____ F____ (or place label here)

Dental Health History & Patient Responsibility Form

We ask these questions to everyone. They go into your health record and are protected under privacy laws. Please be honest, so that we can best plan your care.

Do you need help filling out this form? ❑ Yes ❑ No

Patient Preferred Name: _____ Date of Birth: _____
Parent/Guardian Name: _____ Phone: _____
Emergency Contact Name: _____ Phone: _____

HEALTH HISTORY (Dental Related Questions)

1. **Do you have dental pain?** ❑ Yes ❑ No
2. **Do you have bleeding gums?** ❑ Yes ❑ No
3. **Do you have sensitive teeth?** ❑ Yes ❑ No
4. **Have you had an injury to your face or jaw, or do you have jaw pain?** ❑ Yes ❑ No
5. **Have you had a problem related to dental treatment in the past?** ❑ Yes ❑ No
6. **Do you brush and floss your teeth each day?** ❑ Yes ❑ No
   If yes, how often? Brush _____ /day Floss _____/day
7. **Do you use fluoride (for example, toothpaste, rinses, tablets)?** ❑ Yes ❑ No
   How do you get your fluoride? _____
8. **Have you ever had a partial or full denture?** ❑ Yes ❑ No
9. **When was your last dental visit? Date:** _____
10. **Do you have a medical provider?** ❑ Yes ❑ No
    If yes, please list provider's name and phone number: _____
    If yes, when was your last visit?_____
11. **Tell us about your tobacco use:**
    ❑ **Current every day smoker** ❑ **Former smoker** ❑ **Never smoker**
    What type? ❑ Cigarettes ❑ Pipe ❑ Cigars ❑ Snuff ❑ Chew ❑ Vaping
    Are you ready to quit? ❑ Yes ❑ No
12. **Are you pregnant or are you trying to become pregnant?** ❑ Yes ❑ No ❑ N/A
    Are you breastfeeding? ❑ Yes ❑ No
    Are you currently getting prenatal care? ❑ Yes ❑ No

MEDICATIONS

13. **Please list all medications you are currently taking (include prescriptions, over-the-counter drugs, vitamins and supplements):**

_____

_____

_____

❑ I am not taking any medications

Name: _____
MRN: _____
DOB: ____/____/____ ID#_____
Sex: M ____ F____ (or place label here)

ALLERGIES

14. Do you have any allergies (for example, latex, penicillin)?

❑ **No.** I am not allergic to anything.

❑ **Yes.** Write the name of your allergy:

Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____

HEALTH HISTORY (Medical Related Questions)

15. Have you ever had any of the following conditions? (check all that apply)

- ❑ Abuse as adult (victim)
- ❑ Abuse as child (victim)
- ❑ ADD/ADHD
- ❑ Alcoholism
- ❑ Allergies
- ❑ Anemia
- ❑ Anxiety
- ❑ Arthritis/Joint Disorder
- ❑ Asthma
- ❑ Autism
- ❑ Broken Jaw
- ❑ Cancer
- ❑ Cataracts
- ❑ Clotting Disorder
- ❑ COPD
- ❑ Depression
- ❑ Diabetes Mellitus
- ❑ Drug Addiction
- ❑ Emphysema
- ❑ Glaucoma
- ❑ Heart Disease
- ❑ Heart Failure
- ❑ Heart Murmur
- ❑ Heart: Endocarditis
- ❑ History of Blood Transfusion
- ❑ HIV/AIDS
- ❑ Hyperlipidemia (High Cholesterol)
- ❑ Hypertension (High Blood Pressure)
- ❑ Kidney Disease
- ❑ Liver Disease/Hepatitis
- ❑ Meningitis
- ❑ Mental Health Disorder
- ❑ MRSA History (Staph Infection)
- ❑ Myocardial Infarction (Heart Attack)
- ❑ Nerve/Muscle Disorder
- ❑ Osteoporosis (Bone Weakness)
- ❑ Pacemaker
- ❑ Seizures
- ❑ Sickle Cell Anemia
- ❑ STD (Sexually Transmitted Disease)
- ❑ Stomach Disease
- ❑ Stroke
- ❑ Thyyroid Disease
- ❑ Tuberculosis
- ❑ Other : _____

16. Have you ever had any of the following surgeries?

❑ Joint replacement When? _____ Which joint? _____
❑ Heart surgery When? _____ what kind? _____
❑ Other When? _____ what kind? _____

OTHER

17. Does going to the dentist make you anxious?..... ❑ Yes ❑ No

18. What are your goals for keeping your mouth and teeth healthy?

❑ Floss more ❑ Brush more ❑ Eat/Drink less sugar ❑ Use fluoride toothpaste
❑ Get regular dental check ups ❑ Quit tobacco use

19. How do you learn best?

❑ Reading information ❑ Hearing information ❑ Pictures ❑ Learn by doing (hands on)

20. How do you want to get information?

❑ In writing ❑ Tell me ❑ Show me

21. Is there anything else you would like to discuss with your provider today?

_____
_____

Name: _____
MRN: _____
DOB: ____/____/____ ID#_____
Sex: M ____ F____ (or place label here)

Patient Rights and Responsibilities

Keeping Appointments

- If you cannot come to your appointment, please call the clinic at least 4 hours before your appointment time. This lets us schedule another patient waiting to be seen. If you miss 3 appointments in a rolling 12 months, you will not be able to schedule a dental appointment. Instead, you will be on standby (sit and wait) status for one year. When on standby status, there is no guarantee you will be seen that day. You may also call the same day you would like care to see if a provider has an available appointment.
- Please be on time for your appointments. If you arrive late, your provider may not be able to see you, or may only complete part of your treatment.

Payment Policy

If you are uninsured, you will be expected to pay an out-of-pocket fee at the time of check-in, based on your family size and income.

Children

- A parent or legal guardian must be present at all first, recall & consult exam visits for child(ren) under the age of 15. You can give permission to another caregiver (age 18 or older) to bring your child(ren) to all other visits and consent to treatment after you sign a separate form.
- Your provider will decide if you are allowed to bring your child(ren) with you into the treatment area when you are being treated. You may be asked to bring a friend or family member to watch your children in the waiting area while you are being treated.
- You may be asked to stay in the waiting area while your child(ren) is being treated.

Treatment by Students

We have student dentists, dental hygienists and dental assistants working with us. You may be treated by a student during your appointment.

I have read this form, or it has been read to me, and I understand and agree to all information.

Client, Parent or Guardian Signature **Date**

Dental Provider Signature **Date**

Interpreter Name **Date**