Dental Foundation of Oregon – Tooth Taxi
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_____

School Attending _____ **Grade** _____ **Age** _____ **Sex** (circle) M F

Home Address _____
Street/ P.O. Box City State Zip

Parent or Legal Guardian Name _____

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/Latino Black/African American Asian American Indian Native Hawaiian/Pacific Islander 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*?* _____

Within the last 12 months have you had any concerns about being hungry or running out of food? (circle one) Yes No

Has anyone in your household experienced uncertain/unreliable housing in the last 12 months? (circle one) Yes No

If you were not accessing our program, would you be able to easily access dental care elsewhere for your child? Yes No

Dental History	Yes	No	Please explain answers
Is this the patient's first time having a dental exam?			
If no, has your child been seen by a dentist in the last 12 months?			
Does the patient have to travel more than 30 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?			
Does the patient floss?			If "yes", how often?
Has dental pain caused the patient to miss school in the past year?			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 (√)

☐ Routine exam ☐ Couldn't afford dental care ☐ Couldn't get appointment anywhere else

☐ Toothache/Mouth Pain/Face swelling ☐ Cavities ☐ Other (specify)_____

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?			
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?			
Does the patient smoke, vape or use any type of tobacco products?			
Does the patient have any special needs that would require special arrangements for dental care? i.e. Autism or previous unpleasant dental visit.			

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

☐ Latex allergy	☐ Anemia	☐ Diabetes	☐ Birth defects
☐ AIDS / HIV	☐ Asthma	☐ Epilepsy/seizures	☐ Excessive bleeding
☐ Liver disease	☐ Heart problems	☐ Cancer	☐ Rheumatic fever
☐ Hepatitis	☐ Cerebral Palsy	☐ Tuberculosis	☐ Kidney Disease
☐ Other_____			☐ **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#**_____

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