Multnomah County
Health Department

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. They help us plan your care. Please skip any questions you don't want to answer.

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

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

Would you like to receive text message appointment reminders? ☐Yes ☐No
If yes, please text 'MCHD' to 622622
Mobile Phone (required for text messaging): _____

HEALTH HISTORY
1. **Do you have dental pain, bleeding gums, or sensitive teeth?**.....☐Yes ☐No
2. **Have you had an injury to your face or jaw, or do you have jaw pain?**.....☐Yes ☐No
3. **Have you had a problem related to dental treatment in the past?**.....☐Yes ☐No If yes, please describe_____
4. **Do you brush and floss your teeth each day?**.....☐Yes ☐No If yes, how often? _____
5. **Do you use fluoride (for example, toothpaste, rinses, tablets)?**.....☐Yes ☐No If yes, how often, and in what form? _____
6. **Have you ever had a partial or full denture?**.....☐Yes ☐No
7. **When was the last time you saw a dentist? Date:** _____
8. **Have you ever:** (please circle what you have used) **Smoked cigarettes / cigars / used snuff / e-cigs / vape / chewed tobacco**

If yes, for how many years? _____ How much per day? _____

Have you quit? ☐Yes, when? _____ ☐No If not, do you want to? ☐Yes ☐No

9. Are you pregnant?.....☐Yes ☐No ☐NA

If yes, do you plan on breastfeeding?.....☐Yes ☐No

10. Have you ever been hospitalized?.....☐Yes ☐ No

If yes, please explain: _____

11. 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?_____

12. Have you ever had a bad experience at a dental visit?.....☐Yes ☐No

If yes, please explain: _____

MEDICAL HISTORY

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

☐ Addiction (alcohol or drugs)	☐ Epilepsy (fits, seizures)	☐ Migraine headaches
☐ Anxiety	☐ Heart problems (e.g., heart attack, heart valve)	☐ Skin problems
☐ Asthma	☐ Hepatitis	☐ Steroid therapy
☐ Blood disorders	☐ High blood pressure	☐ STD (e.g., syphilis)
☐ Cancer – what type?	☐ HIV	☐ Stroke
☐ Depression (feeling down or blue)	☐ Joint replacement	☐ Ulcers
☐ Diabetes (sugar control)	☐ Kidney problems	

☐Other_____

14. Please tell us about any other medical conditions not listed above:

_____

_____

MEDICATIONS

15. Are you taking any prescription or over-the-counter medicines? (for example, Lipitor, ibuprofen)

☐ **No.**

☐ **Yes.** Please list your medicines below, or give your provider a list.

_____

_____

ALLERGIES

16. 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: _____

OTHER

17. How do you learn best?

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

18. How do you want to get information?

☐In writing ☐Tell me ☐Show me

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

_____

_____

_____

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**

Your oral health is important to us, and a clean and healthy mouth is important for overall health!