

## INDIVIDUAL PRE-APPOINTMENT ORAL HEALTH INFORMATION FORM

**INTRODUCTION:** An oral health treatment plan is based on each individual's health and oral health status, along with the person's natural responses to oral health care. This form is designed for individuals and their caregivers to capture in writing information needed by the dental team prior to an appointment. This will help determine which dental office is the most appropriate for each person.

Individual's legal name \_\_\_\_\_  
Name prefers to be called \_\_\_\_\_  
Home address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Home phone number \_\_\_\_\_ Cell \_\_\_\_\_ E-mail \_\_\_\_\_  
Case manager/Caregiver/Parent \_\_\_\_\_  
Primary phone number \_\_\_\_\_ E-mail \_\_\_\_\_  
Person accompanying person to dental appointment \_\_\_\_\_  
Primary phone number \_\_\_\_\_ Relationship \_\_\_\_\_  
Primary care physician's name/office phone \_\_\_\_\_

**ORAL HEALTH INFORMATION:** (please identify reason for appointment/check all that apply)

- Regularly scheduled dental exam  
Date of last exam and name of dentist \_\_\_\_\_
- Dental cleaning-prophylaxis  
Date of last cleaning and name of hygienist \_\_\_\_\_
- Appointment is a follow up on previous dental treatment plan
- Care for individual's dental problems (check all that apply)
  - Pain
  - Swelling
  - Bleeding when brushing/flossing
  - Halitosis/Bad breath
  - Chipped/broken/missing tooth/teeth
  - Other \_\_\_\_\_

**HEALTH INFORMATION:**

Medication _____	Dose _____	Frequency _____
Medication _____	Dose _____	Frequency _____
Medication _____	Dose _____	Frequency _____
Medication _____	Dose _____	Frequency _____
Medication _____	Dose _____	Frequency _____
Medication _____	Dose _____	Frequency _____

Health conditions \_\_\_\_\_  
Health conditions \_\_\_\_\_  
Health conditions \_\_\_\_\_  
Health conditions \_\_\_\_\_  
Health conditions \_\_\_\_\_

Does the person have heart problems? Yes \_\_\_\_\_ No \_\_\_\_\_

Does the person have seizures? Yes \_\_\_\_\_ No \_\_\_\_\_

Seizures controlled by medication? Yes \_\_\_\_\_ No \_\_\_\_\_

Seizures even with medication? Frequency \_\_\_\_\_ Duration \_\_\_\_\_

What is the person's behavior during a seizure? \_\_\_\_\_

Name of neurologist? \_\_\_\_\_ Phone \_\_\_\_\_

Has the person had surgery? Yes \_\_\_\_\_ No \_\_\_\_\_

(please specify) \_\_\_\_\_

