

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) _____

