Friends of Creston Children's Dental Clinic
Patient Information Form

THIS FORM IS 4-PAGES

Please fill out this form **completely**.

Patient's Legal Name ____________________ **Birth Date** (mm/dd/yyyy) ____________

Patient Nickname____________ **Parent or Legal Guardian Name** ____________________

School Attending ____________________ **Grade** __________ **Age** ________ **Sex** (circle) M F

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

Phone Numbers: Home (___) ____________ Work (___) ______________ Cell (___) ______________

Emergency Contact: Name __________________ Relation to patient __________ Phone (___) __________

Ethnicity: Which one of these groups would you say best represents the patient's race? (Circle one)

Hispanic *Black or African American* *Asian* *Native Hawaiian or Pacific Islander* *American Indian*
Alaska Native *White* *Other*____________________________

What is the primary language spoken at home? ______________________________

Is English the patient's Second Language (ESL)? (Circle) Yes No

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 under 21 years of age live in your household? ______________________

How did you hear about the clinic? ☐ PPS Staff or Communications ☐ Flyer ☐ Friend ☐ Other

Dental History	**Yes**	**No**	Please explain answers
Is this the patient's first dental visit? If no, how long has it been since the patient last saw a dentist?			
Has the patient had any unpleasant experiences in a dental or medical office?			If "yes" please explain.
Does the patient brush and floss daily?			If "yes" how often?
Does the patient take a fluoride supplement at home or school?			If "yes", how often?
Does the patient drink soda pop or other sugar sweetened drinks daily (Kool-aid, juice, Gatorade, sport drinks, energy drinks)?			How many does the patient drink per day?
Does the patient drink milk daily?			How many times per day?
Has dental pain caused you or your child to miss school and/or work in the past year?			If "yes", circle – school work both 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 (√)

☐ First examination ☐ Accident to teeth ☐ Routine exam ☐ Other (specify)
☐ Toothache ☐ Bleeding around teeth ☐ Couldn't afford dental care ____________
☐ Mouth pain/face swelling ☐ Teeth Appearance ☐ Couldn't get appointment anywhere else

Medical History

THIS FORM IS 4-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?			
Has the patient been diagnosed with autism?			
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?			
Is the patient currently protected by immunization (shots) against DPT (diphtheria, whooping cough, tetanus) polio, measles, mumps, German Measles (rubella) and Hepatitis B?			
Does the patient have any special needs that would require special arrangements for dental care?			

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

- ☐ Latex allergy
- ☐ AIDS / HIV
- ☐ Epilepsy/ seizures
- ☐ Excessive bleeding
- ☐ Chronic ear infections
- ☐ Chronic eye infections
- ☐ Sinus problems
- ☐ Sore throats
- ☐ Anemia
- ☐ Asthma
- ☐ Bladder problems
- ☐ Birth defects
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chicken pox
- ☐ Convulsions
- ☐ Diabetes
- ☐ Fainting
- ☐ Hearing problems
- ☐ Heart problems
- ☐ Hepatitis
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Measles
- ☐ Mono
- ☐ Mumps
- ☐ Rheumatic fever
- ☐ Stomach/ intestinal disorders
- ☐ Tuberculosis
- ☐ Other ___________________
- ☐ Could the patient be pregnant?
- ☐ Have you ever been told that your child needs antibiotics before a dental procedure?

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	

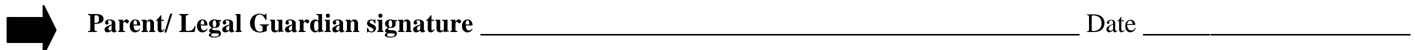
Insurance: **Do you have OHP or other dental insurance coverage? ___Yes ___ No**
ID#___________________________________

CIRCLE your **OHP** Dental Plan and provide a copy of OHP letter that gives ID# & dental assignment:

Advantage **Capitol** **ODS**

Is your child covered under Healthy Kids? ____Yes ____No ***or*** **The Children's Program? ____Yes ____No**

ID#_________________ (Provide copy of enrollment letter with ID#)



Parent/ Legal Guardian signature ____ Date ____________________

Authorization of Release of Protected Health Information

By signing this document, you are allowing the Friends of Creston Children's Dental Clinic staff to give or receive from other health care providers or child agencies your child's health care records to provide the best care for your child. The records may be sent to another dentist, dental specialist or other health care provider that the Creston Dental staff recommends further treat your child. The information may also be shared with an agency that your child is affiliated with (such as school, Head Start, etc.) for record keeping purposes.

Patient's Name ____

I hereby authorize:

Friends of Creston Children's Dental Clinic
4701 SE Bush Street
Portland, OR 97206

to receive from or release to the appropriate health care provider or agency, my child's records to facilitate his or her health care needs and/or treatments.

Name of parent/legal guardian____
(Please print)

Parent/legal guardian signature____Date_______________________

If there are providers or agencies that you do NOT want your child's records released to or received from please list here:

____

HIPAA
Acknowledgement of Receipt of Notice of Privacy Practices

*You May Refuse to Sign this Acknowledgment

Patient Name____

I, ____
(Parent/legal guardian name)

have received a copy of the Friends of Creston Children's Dental Clinic's Notice of Privacy Practices.

Parent/legal guardian signature ____Date_______________________

For Office Use only: *We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because: __Individual refused to sign, __Communications barriers prohibited obtaining the acknowledgment, __ An emergency situation prevented us from obtaining acknowledgment, __Other (Please Specify)_________________

Photo Consent and Release (Optional)

I consent to the use of pictures, video or audio recordings of myself or my child for education, program promotion, including print, audio, video, and web promotion. I also agree that any writing or other material in connection with Friends of Creston Children's Dental Clinic may be used in promotional materials.

Parent/legal guardian signature____Date________________________

Friends of Creston Children's Dental Clinic
Treatment Consent and Agreement Form

I, ______________________________, as a legally responsible guardian of _______________________________________
(Print parent/legal guardian name) (Print child's name)

authorize and request the performance of dental services for child. This treatment may consist of dental x-rays, diagnosis, topical fluoride application and other preventive measures as well as restorations, extractions and preventive orthodontic (dental) procedures as recommended by the Creston Dental dentists. I understand that the Creston Dental dentists will use restorative treatment and behavior management that is reasonable and necessary, including local anesthetics and nitrous oxide as needed. I understand and consent to treatment provided by trained dental, hygiene, and dental assisting students supervised by licensed dentists.

I consent that child may receive dental services provided by Creston Dental, and consent that their dentists and other agents and employees may furnish to Creston Dental employees and/or authorized organizations all information concerning the child's case history, dental examinations, written reports (and any accompanying photographs) with respect to the dental examination and the exam results. An authorized organization is one approved by the Creston Dental program.

I consent and authorize the Friends of Creston Children's Dental Clinic to file and collect any insurance, private or Oregon Medicaid/OHP reimbursement for dental services performed. I also certify that I understand and agree to the conditions described above.

Are you currently the legal guardian for this child?	YES	NO
Can you sign for medical treatment?	YES	NO
I have been informed of the risks involved with dental treatment	YES	NO

Parent/legal guardian name ____
(please print)

Relationship to child____

Signature____Date______________________________

Friends of Creston Children's Dental Clinic
Patient Missed Appointment Policy

Patients who miss their dental appointments disrupt clinic efficiency and deprive other patients of needed appointments. If three (3) consecutive appointments are missed, the patient may not be seen in the clinic.

- The first time a patient misses a dental appointment, without cancelling, the patient/parent/guardian will be reminded of the Patient Missed Appointment Policy.
- The second time a patient misses a dental appointment, without cancelling, a letter will be sent to the parent/guardian of the patient. The letter states that appointments must be kept and that patients arrive on time. The letter also states that if a third appointment is missed, without cancelling, the patient will be dismissed from the clinic.
- The third time a patient misses a dental appointment, without cancelling, the parent/guardian will be told the patient can no longer be seen in the clinic. A letter with this information will be sent stating dismissal from the clinic.

I have read and understand the Patient Missed Appointment Policy. By signing I agree to the conditions of the Patient Missed Appointment Policy.

Signature of parent/legal guardian____ Date__________________