Boys & Girls Club of Albany Dental Clinic
Patient Information Form

Please fill out this form completely. If you have questions, please your school co-coordinator.

Patient 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 (_____) _____________________

Note: Dental visits should start at age 1.

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* *Black or African American* *Asian* *American Indian* *Other*______________

Income: Which of these best represents your annual household income? (circle one)

$0-$12,000 *$12,001-$17,000* *$17,001-25,000* *More than $25,000*

Household Size: How many children less than 21 years of age live in your household? _______________

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?			
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?			If "yes" how often?
Does the patient floss?			If "yes", how often?
Does the patient drink soda pop or other sugar sweetened drinks daily (Kool-aid, fruit drink, Gatorade, sport drinks)?			How many does the patient drink per day?
Does the patient drink milk daily?			How many times per day?
Does the patient sleep with a bottle or use a sippy cup other than at meals?			

Reason for Visit: Check any that apply (√)

- ☐ First examination
- ☐ Accident to teeth
- ☐ Routine exam
- ☐ Other (specify) ____________
- ☐ Toothache
- ☐ Face swelling
- ☐ Teeth appearance
- ☐ General mouth pain
- ☐ Bleeding around the teeth
- ☐ Couldn't get appointment anywhere else

Medical History

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, and German Measles (rubella)?			
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 ___________________

For x-ray purposes:

☐ **Could the patient be pregnant?**

Please explain "yes" answers: ____

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Behavioral Issues	Yes	No	Please Explain "yes" answers
Does the patient have trouble with his/her mood or behavior (such as frequent crying, tantrums, withdrawal or anxiety?)			
Do you think the patient is using drugs or alcohol?			
Do you think the patient currently has an eating disorder or has any history of eating disorders?			
Do you think the patient uses tobacco products (cigarettes, chewing tobacco)?			
Have you noticed any major changes in the patient's behavior, grades, moods, friendships, or leisure activities?			

Does your family use any of these community resources? ___TANF ___Food Stamps ___ OHP ___Free/reduced Lunch

Parent/ Legal Guardian signature ____ Date _____________

OFFICE USE ONLY: ___Photo consent ___Post screening Data Entered ___Visit Summary sent ___Parent ed letter sent ___Parent ed attended