Dental Health Risk Screening Form

This screening is to help us understand your and/or your child's oral health. Our staff will review this form and share it with your dental provider. This screening will help us determine if you have any immediate dental problems. We will help coordinate services you need. Please fill this form out for the person that it was addressed to.

You can get this form in another language, large print, or another way that is best for you. Just call us at (503) 644-2663.

There are several ways to fill out the screening and share your answers with us. You can:

- Call and tell us your answers
- Mail responses using the self-addressed envelope provided to
  6700 SW 105th Ave Suite 210, Beaverton, OR 97008

Tell Us About You and/or Your Child:

Parent/Guardian/Representative Name (If applicable): ____

(Name of Person Filling Out This Form)

Name of Member: ______________________________________ Date of Birth: __________________________

Phone number: ____

Address: ____

E-mail address: ____

Do we have your OK to email you oral health and plan information? Check One: Yes No

Oregon Health Plan Member Identification Number: ____

Primary Care Physician Name: __________________________________ Phone Number: ___________________

Do you have other health insurance? Check One: Yes No

If yes, please specify other insurance: ____

Please check the applicable responses for you and/or the patient:	Yes	No	N/A	Follow-Up Question (if applicable) or comments
Pregnant				Due date:
Smoke, vape or chew tobacco or use tobacco-like products like e-cigarettes, hookah pipes and cigars				
Have diabetes				
Have heart disease				
Live in a long-term care facility (residential or nursing home, or assisted living)				
Have a physical condition that keeps you from normal activity				If yes, please explain:
Have a mental or emotional condition that keeps you from normal activity				If yes, please explain:
Have other diseases or are you receiving treatment(s) that might affect your oral health				If yes, please explain:
Have any limitations that may impact your oral health care				If yes, please explain:
Have a dentist				
Do you need help with getting dental care?				If yes, please explain:
Has it been longer than one year since your last dental cleaning?				If known, what month and year:
Have ongoing dental pain that keeps you from normal activity (such as sleeping, work, school, etc.)				If yes, please explain:
Have dental pain that comes and goes in the past 6 months				If yes, please explain:
Had any pain or aching from chewing, or sensitivity to hot or cold in the past 6 months				If yes, please explain:
Have you had any teeth pulled because of a cavity within the past 6 months				If yes, please explain:
Have a broken tooth now				If yes, please explain:
Taking any prescription medications				If yes, please list:

Anything else we should know:

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