



Maternal Oral Health Intake

Client ID: _____

Admission ID: _____

Client's name (first, middle, last) _____ Maiden name _____

Birth date ____/____/____ Social Security # _____

Client alias _____ Alias Client ID _____

Street address _____ Apt# _____ County _____

City _____ State _____ Zip code _____

Home phone _____ Work phone _____

Message phone _____ Message place _____ Message contact _____

Emergency contact _____ Phone _____ Relationship _____

Contact Date _____

Does client have regular dentist? yes no unknown

Name of dentist: _____

When was last dentist visit? Within 1 year 1-3 years ago More than 3 years ago Never seen a dentist Unknown

Barriers to dental care:

- | | | |
|---|---------------------------------------|--------------------------------|
| <input type="checkbox"/> Cost | <input type="checkbox"/> Office hours | <input type="checkbox"/> Other |
| <input type="checkbox"/> Dentist will not accept Medicaid | <input type="checkbox"/> Fear | (specify) _____ |
| <input type="checkbox"/> Transportation | <input type="checkbox"/> None | |

Dental Insurance:

- | | | |
|---|---|--------------------------------|
| <input type="checkbox"/> Hawk-i | <input type="checkbox"/> private dental insurance | <input type="checkbox"/> other |
| <input type="checkbox"/> Medicaid/Title XIX | <input type="checkbox"/> self-pay | specify _____ |

Does client have any oral concerns or problems? yes no

Specify: _____

Dental Comments:

Intake form completed by:		
Data entered by:		
Quality assurance inspection:		