# Admission - Oral Health History and Preferences

Resident name: _____ Date:_____

## A. Resident Dental History Details

| Questions | Yes | No |
|---|---|---|
| Have you visited the dentist in the last year? | | |
| Would you like to continue to visit your dentist? | | |
| **If yes**, who is your dentist - Name:<br>Address:<br>Phone:<br>Will resident/POA schedule appointments | | |
| **If no**, home's external dental service provider information given to resident/POA: | | |
| Resident/PAO signed consent for home's external dental services provider: | | |
| **Dentures** | | |
| How old are your dentures? | | |
| Have your dentures been assessed in the last year? | | |
| Denture(s) labelled | | |
| Indicate type(s) | □ **Upper full denture**<br>□ **Lower full denture**<br>□ **Upper partial denture**<br>□ **Lower partial denture** | |
| Any other restorative dental appliances? | □ **Crowns**<br>□ **Implants**<br>□ **Bridge**<br>□ **Other** | |

## B. Preferred Level of Oral Care (check one)

□ **Minimal Oral Care –** oral care is a low priority, may not want daily oral care. Will see dental professionals only as needed

□ **Comfort Oral Care –** maintain current oral status – daily oral care measures provided. Visit dental professionals as needed

□ **Maximum Oral Care –** oral care is a priority - provide good oral care at least two times a day and visit dental professionals regularly

## C. Resident Oral Health Preferences

| | |
|---|---|
| How often would you like oral care? | |
| What oral care products do you like to use? | □ Toothbrush<br>□ Electric toothbrush<br>□ Mouth rinse<br>□ Other:_____ |
| When do you prefer to have you oral care completed? | **Morning:**<br>□ Upon waking/with morning care<br>□ After breakfast<br>□ After morning snack<br>□ Other:_____<br>**Evening:**<br>□ After supper<br>□ Before getting into bed<br>□ Other:_____ |

## D. Resident Oral Health Assessment

Use your homes standard oral health assessment tool to complete an oral health status exam (Example: Oral Health Assessment Tool (OHAT))