Dental Emergency Report

Patient

Facility Name
Facility Phone #

Is resident an Access Dental Care patient of record? ☐ **Yes** ☐ **No**
If you checked **No**, send a completed *Consent for Dental Services* form with this report

Denture Concern

☐ Upper full denture ☐ Lower full denture ☐ Upper partial ☐ Lower partial

Describe the denture concern: _____

Is this patient in pain? ☐ **Yes** ☐ **No**
If Yes, please explain the nature of the pain: _____

Tooth Concern

☐ Upper Right ☐ Upper Left ☐ Lower Right ☐ Lower Left
☐ Upper Front ☐ Lower Front

Describe the tooth concern: _____

Is this patient in Pain? ☐ **Yes** ☐ **No**
If yes, is the pain constant? ☐ **Yes** ☐ **No**
Describe the nature of the pain _____

Is the patient taking pain medication? ☐ **Yes** ☐ **No**
If yes, what? _____ Is the medicine specific to this problem?_____
Is the patient having trouble eating? ☐ **Yes** ☐ **No**
Is there any swelling? ☐ **Yes** ☐ **No**
If yes, describe:_____

Please list any allergies this patient has:_____

Please print facility contact person:_____**phone**_____

Signature_____ **Date** _____

For Access Dental Care Use Only:

Signature Date

revised 05/2011