



NEW PATIENT INFORMATION

Welcome to the UCSF School of Dentistry Dental Clinics!

We are located at 707 Parnassus Avenue, San Francisco, California 94143-0752 For information and or appointments in our clinic, please call (415)476-1891 or visit our website http://dentistry.ucsf.edu/patients/patients_main.html

Dental care in the **Predoctoral practice** is provided by dental students under the direct supervision of faculty dentists. The purpose of your first visit with us is to assess your overall dental conditions and report our limited findings. **There is a \$11 fee for this assessment.** In addition, our evaluation allows us to determine which of our three clinical practices would best fit your needs if you choose to become a patient in the School of Dentistry. Our three practices are: the Predoctoral Clinic, the Postgraduate Clinics, and the Faculty Group Practices. While it takes longer to complete treatment than in a private office (most appointments last approximately three hours), the fees in the Predoctoral clinic are generally less than the cost of a private office. Patients with complex dental or health conditions or treatment needs are beyond the scope of the Predoctoral Clinics. These patients will be referred to more advanced providers. When the initial evaluation is completed you will be assigned to one of our three practices based on a discussion with you about which practice best fits your dental and health needs. If you become a patient in the Predoctoral clinic, you will be assigned to a primary and possibly a secondary student co-provider.

You will be given an appointment as soon as possible. Please be prompt or early to your appointed time, which is reserved for you. If you are unable to keep your appointment, please call us at (415) 476-1891 so that we can reschedule your appointment. **There will be a charge of \$10 for each broken appointment or when you cancel your appointment with less than 24 hours advance notice. The dental chair assigned for you and your student-dentist is reserved until twenty minutes after your appointed time. After that, the chair is reassigned to another student-dentist and you will be charged a broken appointment.**

Your first appointment as a **patient of record** in the Predoctoral clinic will be to start your comprehensive oral examination (complete set of X-rays are necessary), discuss our findings and formulate a plan to restore your dental health and implement preventive care to reduce or eliminate future dental disease. We encourage you to ask questions if you need information or clarification on our clinic policies, procedures or treatment modalities. If you have x-rays from a previous dentist, please bring them with you if possible. If you do not have recent, acceptable x-rays, we can take them at the school.

Treatment in the Predoctoral Clinics must be paid in-full at the time of service. We cannot make future appointments for patients with an account balance. As a convenience for our patients, we do accept major credit cards and checks.

If you are referred to either a Postgraduate or Faculty dental practice, you will be given the appropriate telephone number to call at your convenience to schedule a comprehensive examination or consultation appointment.

Dental care in the **Postgraduate Clinics** is provided by dentists taking advanced training in specialty areas. The fees are higher than the Predoctoral clinic, but less than those of a private dentist.

Dental care in the **Faculty Group Practices** is provided by the teaching faculty in group dental practice settings and the fees are similar to those in the community.

THANK YOU FOR THE OPPORTUNITY TO SERVE YOU!



UCSF SCHOOL OF DENTISTRY
Patient Registration Form

CONFIDENTIAL

Date _____

1. Name _____
Last First MI

2. Gender (Circle) Male Female Transgender

3. Date of Birth: _____ SS#: _____

4. Street Address: _____

5. City: _____ State: _____ Zip Code: _____

Please place an asterisk (*) Next to the best phone number to contact you below!

6. Home Phone: () _____ Work Phone : () _____

Cell Phone: () _____ Other Phone: () _____

7. Do you have Denti-Cal (Welfare) or Private Insurance (Circle): Yes No
"Please present Denti-Cal-Card/Insurance Card and Valid California ID to the staff"

8. Disability(circle) Yes No If yes, please indicate: Partial Total
Temporary Permanent

9. Please select your racial background (You may select more than one):

- | | |
|--|--|
| <input type="checkbox"/> African-American/Black/Haitian | <input type="checkbox"/> Hawaiian |
| <input type="checkbox"/> American Indian /Native Amer/Alaskan Native | <input type="checkbox"/> Indian |
| <input type="checkbox"/> Bangladeshi | <input type="checkbox"/> Indonesian |
| <input type="checkbox"/> Burmese/Myanmarese | <input type="checkbox"/> Japanese |
| <input type="checkbox"/> Caucasian /white/Middle Eastern | <input type="checkbox"/> Korean |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Laotian |
| <input type="checkbox"/> Central American | <input type="checkbox"/> Malaysian |
| <input type="checkbox"/> Cuban | <input type="checkbox"/> Mexican/Latino/American |
| <input type="checkbox"/> Fijian | <input type="checkbox"/> Other Asian |
| <input type="checkbox"/> Filipino | <input type="checkbox"/> Pakistani |
| <input type="checkbox"/> Guamanian | <input type="checkbox"/> Thai |
| | <input type="checkbox"/> Do not wish to respond |

10. In order to IMPROVE our oral health services for you-our patients-please indicate the languages you speak, and if you need a clinician who speaks this language.

Language Spoken: Mark ALL that apply.

English Mandarin Farsi Tagalog
 Spanish Korean Tagalog Hindi
 Cantonese Russian Other _____

Do you need an interpreter? (circle) **Yes** **No**

11. How do you hear from about UCSF Dental School: _____

Emergency Contact Information

Name of significant other/closest relative _____ Relationship _____

Home Phone: () _____ Cell Phone: _____ Work Phone: _____

In Case we cannot reach this contact person; Back -up person contact:

Name: _____ Phone number: _____ Relationship: _____

Financial Responsible Party (If it is the same as the patient, proceed to Insurance Information).

Name: _____ Relation to Patient _____

 Last First MI

Social Security Number: _____ Date of Birth: _____

Phone number:() _____ Work number: () _____

Cell number: () _____ Contact E-mail _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Dental Insurance Information

Insurance Name: _____ Group number: _____

Policy Number: _____ Effective Date: _____

Mailing Address: _____ Phone number:() _____

Do you have other DENTAL coverage?(circle) **Yes** **No**

If yes, please fill out the information below for the second coverage.

Policy Holder's Name: _____ Date of Birth: _____

 Last First MI

Social Security #: _____ Gender: Male Female Transgender

Phone number: () _____ Relationship to Patient _____

Insurance Name: _____ Group number _____

Policy Number: _____ Effective Date: _____

Mailing Address: _____



UCSF SCHOOL OF DENTISTRY
Medical History

CONFIDENTIAL

Date _____

Consents/Cultural Considerations

- 1. Do you sign your own consents for health care? Y N
- 2. Which languages do you speak? _____
- 3. If possible do you prefer a clinician who speaks your first language? Y N
 - a. Which language? _____
- 4. Do you need an interpreter? Y N
- 5. Do you have any personal or cultural health beliefs that are important for us to know?

Medical History

- 6. Do you have a medical problem requiring ongoing care or monitoring? Y N
- 7. Do you have a primary care doctor? Y N
 - a. Name and Phone Number: _____
- 8. In case of an emergency, who should we call?
a. Name and Phone number: _____
- 9. What is your impression of your health? _____
- 10. Have you had any serious illness or been hospitalized? Y N
 - a. Please explain: _____

Surgery:

- 11. Have you had any surgeries? Y N
 - a. Please explain: _____
- 12. Do you have any artificial implants or joints? Y N
 - a. Please explain: _____

For Women

- 13. Are you pregnant? Y N
 - a. Number of weeks? _____
- 14. Are you trying to become pregnant? Y N
- 15. Are you presently nursing? Y N
- 16. If past pregnancies, were there any complications? Y N
 - a. Please explain: _____

Medications and Allergies:

- 17. Are you taking any prescription medications: Y N
 - a. Please list: _____
- 18. Are you taking or have you ever taken drugs such as Actonel, Fosomax, Boniva, Zometa, Aredia? Y N
 - a. Please explain: _____
- 19. Are you taking any over the counter, vitamins, or herbal medications? Y N
 - a. Please list: _____
- 20. Have you had an allergic reaction to any medication? Y N
 - a. Please explain: _____
- 21. Have you had an allergic reaction to local anesthetic, latex, or dental materials? Y N
 - a. Please explain: _____

Heart

- 22. Do you experience chest pain? Y N
 - a. Comments: _____
- 23. Have you had a heart attack? Y N
 - a. Comments: _____
- 24. Have you had a heart surgery? Y N
 - a. Comments: _____
- 25. Do you have high blood pressure? Y N
 - a. Do you know your usual blood pressure? _____
- 26. Do you have any other heart problems we have not talked about? Y N
 - a. Please explain: _____

(OVER)

Lungs:

27. Do you have Asthma? Y N
a. Comments: _____
28. Do you have shortness of breath? Y N
a. Comments: _____
29. Do you have any other lung disease? Y N
a. Please explain: _____

Kidney:

30. Do you have any kidney problems? Y N
a. Please explain: _____

Liver:

31. Have you been diagnosed with hepatitis? Y N
a. What type? _____
32. Do you have any other liver disease? Y N
a. Please explain: _____

Endocrine:

33. Have you been diagnosed with diabetes? Y N
a. Do you know your sugar level this morning? _____
34. Do you have thyroid disease: Y N
a. Please explain: _____

GI:

35. Do you have stomach or intestinal problems? Y N
a. Please explain: _____

Neurologic:

36. Do you have seizures? Y N
a. Please explain: _____
37. Do you have any other neurologic problems? Y N
a. Please explain: _____
38. Do you experience anxiety or depression? Y N
a. Please explain: _____
39. Have you been treated for chronic pain? Y N
a. Please explain: _____

Others:

40. Have you been diagnosed with HIV? Y N
a. Do you know your CD4 (T-cell) count? _____
b. Do you know your viral load? _____
41. Have you been diagnosed with cancer: Y N
a. What type? _____
b. How was it treated? _____
42. Any change in your appetite or weight loss? Y N
a. Please explain: _____
43. Any change in your sleep pattern or insomnia? Y N
a. Please explain: _____

Social History:

44. What is the nature of your work? _____
45. Do you use Tobacco in any form? Y N
a. How much do you smoke in a day or a week? _____
b. Is this same or different from the past? How? _____
c. Are you interested in quitting? _____
46. Do you drink alcohol? Y N
a. How much alcohol do you drink in a day or week? _____
b. Is this same or different from the past? How? _____
47. Do you use any type of drug? Y N
a. How much do you use in a day or week? _____
b. Is this same or different from the past? How? _____
48. Are there any other medical problems or conditions that we have not talked about?

Now or in the past, have you ever had:

20. Any difficulty opening or closing or locking in your jaw?

Please explain: _____

21. Any braces or orthodontic work to straighten your teeth?

Please explain: _____

22. Any extractions, oral surgery, or tooth implants?

Please explain: _____

23. Any family history of losing teeth early?

Please explain: _____

24. Any gum or periodontal surgery?

Please explain: _____

25. Any root canal or endodontic treatment?

Please explain: _____

26. Do you have a partial or complete denture? Indicate which: partial or complete

27. Any problems with your denture?

Please explain: _____

28. Who was your previous dentist? _____

What led up to leaving his/ her care? _____

29. List name, address, phone number of dentist? _____

Date of most recent dental Xrays? _____

30. Date of last dental cleaning? _____

Statement of Educational Philosophy

UCSF School of Dentistry

We, the faculty, students and staff of the UCSF School of Dentistry, are committed to fostering an environment of mutual trust and respect.

We believe this goal requires clear communication, compassion for others, and enthusiasm for the dental profession. To this end, we accept personal responsibility for our interactions with patients and colleagues and we encourage one another through constructive guidance. This team philosophy will be the foundation of all our endeavors, even in challenging times. In this way, we will continue to achieve academic and clinical excellence, create lifelong professional partnerships, and provide lasting contributions to the greater community.