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  Temporary  Total  Permanent

9. Please select your racial background (You may select more than one):
   ___African-American/Black/Haitian     ___Hawaiian
   ___American Indian /Native Amer/Alaskan Native     ___Indian
   ___Bangladeshi     ___Indonesian
   ___Burmese/Myanmarese     ___Japanese
   ___Caucasian /white/Middle Eastern     ___Korean
   ___Chinese     ___Laotian
   ___Central American     ___Malaysian
   ___Cuban     ___Mexican/Latino/American
   ___Fijian     ___Other Asian
   ___Filipino     ___Pakistani
   ___Guamanian     ___Thai
   ___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:____________________________________
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? ___________________________
   a. Please explain: ___________________________________________
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?  
   a. Comments: __________________________________________________  
   Y  N
28. Do you have shortness of breath?  
   a. Comments: __________________________________________________  
   Y  N
29. Do you have any other lung disease?  
   a. Please explain:__________________________________________________  
   Y  N

**Kidney:**
30. Do you have any kidney problems?  
   a. Please explain:__________________________________________________  
   Y  N

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

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

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

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

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

**Social History:**
44. What is the nature of your work?  
   ____________________________________________________________  
   Y  N
45. Do you use Tobacco in any form?  
   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? ____________________________________  
   Y  N
46. Do you drink alcohol?  
   a. How much alcohol do you drink in a day or week?______________________  
   b. Is this same or different from the past? How?________________________  
   Y  N
47. Do you use any type of drug?  
   a. How much do you use in a day or week?_______________________________  
   b. Is this same or different from the past? How?________________________  
   Y  N
48. Are there any other medical problems or conditions that we have not talked about?  
   ________________________________________________________________  
   Y  N
1. What is the reason for your visit today? ________________________________________________________________

2. Are you in pain or discomfort today? Y N
   Rate pain severity on 0-10 scale with zero= no pain and ten = worst pain
   0 1 2 3 4 5 6 7 8 9 10
   Please explain: (Include characteristics of pain: location, onset, duration, sharp or dull, known cause, aggravators/relievers, taking any medication to relieve pain?) __________________________________________

3. Any thoughts about what might be causing your dental problems? ________________________________

4. Have you had any negative experiences at the dentist or during dental treatment? Y N
   Please explain:____________________________________________________________________________________

5. How much worry, fear, or anxiety do you experience at the dentist? Rate fear 0 – 10:
   0 1 2 3 4 5 6 7 8 9 10
   Please explain:____________________________________________________________________________________

6. Any trouble sleeping the night before a dental appt or fainting during an appt?
   Please explain:____________________________________________________________________________________

7. Is there anything we could do to make you more comfortable?
   Please explain:____________________________________________________________________________________

8. Do you clench or grind your teeth? Y N

9. Do you have trouble getting or staying numb with dental anesthesia? Y N
   Please explain:____________________________________________________________________________________

10. Is your bite uncomfortable? Y N
    Please explain:____________________________________________________________________________________

11. Are your teeth sensitive to cold, hot, sweet, or pressure? (circle all that apply)
    Cold Hot Sweet Pressure

12. Do you have pain or numbness in your lips, tongue, or soft areas of mouth? (eg. gums/ under the tongue, cheeks)
    Please explain:____________________________________________________________________________________

13. Do you have any pain or numbness in your ears, scalp, temples, or jaw?
    Please explain:____________________________________________________________________________________

14. Do you have difficulty chewing or swallowing?
    Please explain:____________________________________________________________________________________

15. Do you have a problem with acid reflux, vomiting, or weight loss?
    Please explain:____________________________________________________________________________________

16. Do you have any swelling in your face, neck, or any part of your mouth?
    Please explain:____________________________________________________________________________________

17. Do you have any bleeding when brushing or flossing?
    Please explain:____________________________________________________________________________________

18. Do you have trouble cleaning your teeth?
    Please explain:____________________________________________________________________________________

19. Are there any teeth, in particular, you are worried about losing? __________________________________________

(OVER)
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.