UCLA School of Dentistry
Dental Clinics

REGISTRATION QUESTIONNAIRE

Date: _____

Patient: _____
Last Name First Name MI

Home Address: _____
Street Apt# City State Zip

Home Phone#: ( ) _____ **Work Phone#:** ( ) _____

Cell Phone#: ( ) _____

Birth Date: ____/____/____ Sex: ☐ Male ☐ Female ☐ Transgender

Nearest Relative/Friend: _____/_____ Phone ( ) _____
(Not living with patient) Name Relationship

Has the patient ever received dental treatment at UCLA? ☐ No ☐ Yes

If yes, what year/under what name: _____ / _____
Year Last Name First Name MI

Patient Ethnicity: ☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ American Indian/Alaska Native
☐ Asian ☐ Native Hawaiian/Other Pacific Islander
☐ More than one race: _____

Additional Contact Information:
To ensure reliable contact between you, the patient, and UCLA Dental Clinics staff, students, and faculty, **YOU ARE REQUIRED TO PROVIDE A VALID E-MAIL ADDRESS** in the event we need to contact you regarding clinic policy changes and/or your pertinent medical information (i.e., test results, etc.). E-mail will be used **INTERNALLY ONLY** to provide updates and/or promotions as related to patient care and **WILL NOT BE DISTRIBUTED** outside the UCLA Dental Clinics.

E-mail: _____
☐ I wish to opt-out of receiving e-newsletters from the UCLA Dental Clinics.

Medi-Cal & Dental Insurance Information: **Medi-Cal#:** _____

Dental Insurance Policy Holder: _____

Insurance Co.: _____ **Group#:** _____ **Policy #:** _____

Holder's Employer: _____
Company Street City State Zip

Health Questionnaire

Name: _____

Patient History	**YES**	**NO**
Has anything changed in your medical history?	o	o
Major dental problem or reason for coming to the UCLA Dental Center:	_____	
Please describe your general health:	_____	
Current weight:	_____	
Current height:	_____	

Do you or have you ever had any of the following?

Injury to head, neck, jaw or teeth	o	o
Recurrent head, face, jaw or neck pain	o	o
Difficulty opening or closing jaw	o	o
Sore throat, hoarseness or diffculty swallowing	o	o
Dry mouth, recurrent oral sores or irritation	o	o
Bleeding, infected gums or loose teeth	o	o
Decayed or broken teeth	o	o
Poor sleep, snoring or daytime sleepiness	o	o
High blood pressure	o	o
Angina, chest pain or heart attack	o	o
Irregular or rapid heart beats	o	o
Pacemaker or defibrillator	o	o
Murmur, valvular disease or other heart defect	o	o
Artificial heart valve	o	o
Heart failure	o	o
Stroke	o	o
Emphysema or chronic bronchitis	o	o
Asthma	o	o
Lung infections (pneumonia, tuberculosis, other)	o	o
Anemia	o	o
Bleeding disorder or excessive clotting	o	o
HIV infection or other immune deficiency	o	o
Autoimmune disease (RA, lupus, other)	o	o
Cancer	o	o
Radiation or chemotherapy for cancer	o	o
Organ transplant	o	o
Diabetes	o	o
Thyroid disease	o	o
Adrenal or other endocrine disease	o	o
Currently pregnant or breast feeding	o	o
Reflux, peptic ulcer or colon disease	o	o
Hepatitis or other liver disease	o	o

	YES	NO
Renal dialysis or other kidney disease	o	o
STD (syphilis, gonorrhea, HSV, HPV or other)	o	o
Arthritis, persistent stiffness, painful joints	o	o
Artificial joint, implant	o	o
Treatment for osteoporosis	o	o
Seizures	o	o
Numbness, tingling or paralysis	o	o
Muscle weakness or multiple sclerosis	o	o
Movement disorders (Parkinson's, other)	o	o
Cognitive impairment (Alzheimer's, other)	o	o
Depression, anxiety disorder	o	o
Psychiatric conditions (Schizophrenia, other)	o	o
Do you/have you ever smoked/used tobacco?	o	o
Do you or have you ever abused alcohol?	o	o
Do you or have you ever used illicit substances?	o	o

ALLERGIES

Penicillin	o	o
Sulfa drugs	o	o
Dental anesthetics	o	o
Metals (rings or earrings)	o	o
Latex	o	o
Other	_____	

Has anyone in your immediate family ever had:

Heart disease	o	o
Blood disorder	o	o
Cancer	o	o
Tuberculosis	o	o
Mental/emotional disorders	o	o

Medications _____ _____

_____ _____

_____ _____

_____ _____

Please list all hospitalizations and emergency room visits:

Visit 1 Date _____

Visit 1 Reason _____

Visit 2 Date _____

Visit 2 Reason _____

Visit 3 Date _____

Visit 3 Reason _____

UCLA School of Dentistry
Patient Appointment No-Show/ Failure Policy

PLEASE READ THIS CAREFULLY

The importance of honoring confirmed appointments cannot be stressed too much. If you do not give your dentist a 24 hour advance notice to cancel your appointment, a NO-SHOW FAILURE FEE OF $57.00 WILL BE CHARGED TO YOUR ACCOUNT. This fee must be paid prior to your next appointment. Therefore, it is imperative that you communicate with your dentist with a minimum of 24 hours notice if any appointment changes need to be made.

Supplementary Term and Conditions of Service.

In addition to the above policy, patients must give a minimum of 24 hours notice to cancel or reschedule appointments, otherwise appointments will be considered "broken", If any patient falls to show up for a scheduled appointment or if any patient arrives more than 30 minutes late, the appointment will be considered "failed" and the patient may not be able to be seen that day. Three (3) "broken" or "failed" appointments constitute grounds for terminating treatment and the patient will be referred elsewhere.

I understand and AGREE to abide with the above mentioned rules.

_____

Patient Name

_____

Patient Signature OR Guardian Signature

_____

Date

NOTICE OF PRIVACY PRACTICES
ACKNOWLEGEMENT OF RECEIPT

The UCLA HS Notice of Privacy Practice provides information about how we may use and disclose protected health information about you.

In addition to the copy we are providing you, copies of the current notice are available by accessing our website at https://www.dentistry.ucla.edu/patient-care/hipaa-information and may be obtained throughout UCLA HS.

I acknowledge that I have received the Notice of Privacy Practices

_____ _____

Signature of Patient or Patient's Representative Date

_____ _____

Print Name Relationship to Patient

_____

Interpreter (if applicable)

Information below this line for use by UCLA HS only

WRITTEN ACKNOWLEDGEMENT NOT OBTAINED

Please document your efforts to obtain acknowledgement and reason it was not obtained.

- ☐ Notice of Privacy Practices Given – Patient Unable to Sign
- ☐ Notice of Privacy Practices Given – Patient Declined to Sign
- ☐ Notice if Privacy Practices and Acknowledgement Mailed to Patient
- ☐ Other Reason Patent Did Not Sign _____

_____

_____ _____

Signature of UCLA HS Representative Date

_____ _____

Print Name Clinic