UCLA Dentistry
Wilson-Jennings-Bloomfield
UCLA Venice Dental Center

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

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HEALTH QUESTIONNAIRE

Patient Name: _____

Major dental problem or reason for coming to the UCLA Dental Center: _____

_____

Please describe your general health: _____

What is your current weight? _____ What is your height? _____

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

		Yes	No
1.	Injury to head, neck, jaw or teeth	☐	☐
2.	Recurrent head, face, jaw or neck pain	☐	☐
3.	Difficulty opening or closing jaw	☐	☐
4.	Sore throat, hoarseness or difficulty swallowing.	☐	☐
5.	Dry mouth, recurrent oral sores or irritation	☐	☐
6.	Bleeding, infected gums or loose teeth	☐	☐
7.	Decayed or broken teeth	☐	☐
8.	Poor sleep, snoring or daytime sleepiness	☐	☐
9.	High blood pressure	☐	☐
10.	Angina, chest pain or heart attack	☐	☐
11.	Irregular or rapid heart beats	☐	☐
12.	Pacemaker or defibrillator	☐	☐
13.	Murmur, valvular disease or other heart defect	☐	☐
14.	Artificial heart valve	☐	☐
15.	Cardiac or vascular surgery	☐	☐
16.	Heart failure	☐	☐
17.	Stroke	☐	☐
18.	Emphysema or chronic bronchitis	☐	☐
19.	Asthma	☐	☐
20.	Lung infections (pneumonia, tuberculosis, other)	☐	☐
21.	Anemia	☐	☐
22.	Bleeding disorder or excessive clotting	☐	☐
23.	HIV infection or other immune deficiency	☐	☐
24.	Autoimmune disease (RA, lupus, other)	☐	☐
25.	Cancer	☐	☐
26.	Radiation or chemotherapy for cancer	☐	☐
27.	Organ transplant	☐	☐
28.	Diabetes	☐	☐
29.	Thyroid disease	☐	☐
30.	Adrenal or other endocrine disease	☐	☐
31.	Currently pregnant or breast feeding	☐	☐
32.	Reflux, peptic ulcer or colon disease	☐	☐
33.	Hepatitis or other liver disease	☐	☐
34.	Renal dialysis or other kidney disease	☐	☐
35.	STD (syphilis, gonorrhea, HSV, HPV or other)	☐	☐
36.	Arthritis, persistent stiffness, painful joints	☐	☐
37.	Artificial joint, implant	☐	☐
38.	Treatment for Osteoporosis	☐	☐
39.	Seizures	☐	☐
40.	Numbness, tingling, or paralysis	☐	☐
41.	Muscle weakness or multiple sclerosis	☐	☐
42.	Movement disorders (Parkinson's, other)	☐	☐
43.	Cognitive impairment (Alzheimer's, other).	☐	☐
44.	Depression, anxiety disorder	☐	☐

		Yes	No
45.	Psychiatric conditions (schizophrenia, other)	☐	☐
46.	Do you/ have you ever smoked/ used tobacco?	☐	☐
47.	Do you or have you ever abused alcohol?	☐	☐
48.	Do you or have you ever used illicit substances?	☐	☐
49.	Any other medical conditions not listed above	☐	☐
	Please specify		

Allergies

		Yes	No
50.	Penicillin	☐	☐
51.	Sulfa drugs	☐	☐
52.	Dental anesthetics	☐	☐
53.	Metals (rings or earrings)	☐	☐
54.	Latex	☐	☐
55.	Other	☐	☐
	Please specify		

Has anyone in your immediate family ever had?

56.	Heart disease	☐	☐
57.	Diabetes	☐	☐
58.	Blood disorder	☐	☐
59.	Cancer	☐	☐
60.	Tuberculosis	☐	☐
61.	Mental/emotional disorders	☐	☐

Please list all hospitalizations and emergency room visits (include dates and reasons):

1.	4.
2.	5.
3.	6.

Please list all prescriptions and non-prescription drugs you are currently taking (include doses and reasons):

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.