Campus Health Center
UNIVERSITY OF CALIFORNIA, RIVERSIDE

Welcome! Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us. We will be happy to help.

PATIENT INFORMATION (Confidential)

Student ID #_____

Email Address_____ Date_____

Name: _____Birth date:_____Home Phone_____

Cell Phone_____

Address:_____City_____State_____Zip_____

Are you a minor ? ☐ Yes ☐ No

Patient's or Parents Employer_____Work Phone___ _____

Business Address_____City_____State_____Zip_____

Spouse or Parent's Name_____Employer_____Work Phone_____

PATIENT MEDICAL HISTORY

	Yes	No
1. Are you under medical care now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain_____ _____	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medications? _____ _____	☐	☐
4. Have you ever taken Phen-Fen? …..	☐	☐
5. Do you use tobacco?…….	☐	☐
6. Do you use controlled substances?..	☐	☐
7. Are you wearing contacts?……..	☐	☐

	Yes	No
8. Are you allergic to or have had any reactions to the following? :		
Local anesthesia (e.g. Novocain)…..	☐	☐
Penicillin or any other Antibiotics…	☐	☐
Sulfa Drugs …….	☐	☐
Barbiturates ……	☐	☐
Sedatives…….	☐	☐
Iodine……..	☐	☐
Aspirin……	☐	☐
Any Metals (nickel, mercury, etc.)..	☐	☐
Latex Rubber……	☐	☐
Other (please list)_____ _____	☐	☐
9. Women Only:		
a Are you pregnant or think you may be pregnant?…….	☐	☐
b Are you nursing?……..	☐	☐
c Are you taking oral contraceptives?.	☐	☐

10. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure…	☐	☐	Heart Disease …….	☐	☐	Chest Pains…….	☐	☐
Heart Attack……	☐	☐	Cardiac Pacemaker..	☐	☐	Easily Winded …	☐	☐
Rheumatic Fever…….	☐	☐	Heart Murmur …….	☐	☐	Stroke……..	☐	☐
Swollen Ankles ……..	☐	☐	Angina ……	☐	☐	Hay Fever/		
Fainting/Seizures…… .	☐	☐	Frequently Tired…..	☐	☐	Allergies……..	☐	☐
Asthma…….	☐	☐	Anemia…….	☐	☐	Tuberculosis ……	☐	☐
Low Blood Pressure …..	☐	☐	Emphysema…….	☐	☐	Radiation Therapy	☐	☐
Epilepsy/Convulsions….	☐	☐	Cancer …….	☐	☐	Glaucoma…….	☐	☐
Leukemia ……..	☐	☐	Arthritis……..	☐	☐	Weight Loss …….	☐	☐
Diabetes…….	☐	☐	Joint Replacement..	☐	☐	Liver Disease……	☐	☐
Kidney Diseases ……..	☐	☐	Implants……..	☐	☐	Heart Trouble…..	☐	☐
AIDS or HIV…….	☐	☐	Hepatitis/Jaundice …	☐	☐	Respiratory Prob..	☐	☐
Thyroid Problem ……..	☐	☐	Sexually Trans. Dis..	☐	☐	Mitral Valve Pro..	☐	☐
Stomach Problems …….	☐	☐	Ulcers ……	☐	☐	Other_____	☐	☐

Patient Dental History

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold ?…….	☐	☐
3. Are your teeth sensitive to sweet or sour?…….	☐	☐
4. Do you feel pain to any of your teeth?……..	☐	☐
5. Do you have any sores or lumps in or near your mouth?……..	☐	☐
6. Have you had any head, neck or jaw injuries?….	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking……	☐	☐
Pain (joint, ear, side of face…….	☐	☐
Difficulty in opening or closing……	☐	☐
Difficulty in chewing……..	☐	☐

	Yes	No
8. Do you have frequent headaches?……	☐	☐
9. Do you clench or grind your teeth?…….	☐	☐
10. Do you bite your lips or cheeks frequently	☐	☐
11. Have you ever had any difficult extractions in the past?……	☐	☐
12 . Have you had any prolonged bleeding following extractions?…….	☐	☐
13. Have you had any orthodontic treatment?.	☐	☐
14. Do you wear dentures or partials……..	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? …….	☐	☐
16. Do you like your smile?……..	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or any dependents.

X_____

Signature of patient (or parent if a minor)

Medical Changes:_____

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