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.
Dental Patient Bill of Rights and Responsibilities

The Patient Rights and Responsibilities printed below apply to every patient in our clinics with the understanding that the University of California, San Francisco, in conformance with the applicable laws and regulations, does not discriminate on the basis of race, color, national origin, gender, handicap, sexual orientation, or age. We encourage patients to be informed about all aspects of their care. Your dental care provider and teaching faculty are the best persons to ask about the treatment and care you receive at the school.

All Patients Of The School of Dentistry Have A Right To:

• Considerate and respectful care.

• Know the name of the dental care provider.

• Be informed of risks as well as the nature of procedures, expected benefits, and the availability of alternative methods of treatment and the risk of no treatment.

• Ask your dental provider to discuss all the treatment options regardless of coverage or cost.

• Know in advance the type and expected cost of treatment.

• Examine and receive an explanation of the statement of charges.

• Be informed of continuing dental health care requirements.

• Reasonable continuity of care and completion of treatment.

• Expect dental team members to use appropriate infection and sterilization controls.

• Privacy concerning the dental care program.

• Confidentiality of all communications and records pertaining to care. You are entitled to access the information contained in your patient record, within the limits of the law.

• Have these patient rights apply to the person who may have legal responsibility to make decisions regarding dental care on behalf of the patient.
• Treatment that meets the Standard of Care

• To express concerns or complaints about your care with the assurance that the presentation of a complaint will not compromise the quality of your care.

• Exercise these rights and have reasonable access to treatment in clinics.

As a patient at the Dental Clinics at UCSF, you also have the following Responsibilities:

• To report to the best of your knowledge, accurate and complete information regarding any matters pertaining to your health to your dental provider and other health care professionals caring for you.

• To follow the treatment plan recommended by your dental provider (subsequent to informed consent and your authorization to begin treatment)

• To keep appointments.

• To accept the consequences of your own decisions and actions, if you choose to refuse treatment or not to comply with the instructions given by the dental provider.

• To assure that your financial obligations for your health care are fulfilled as promptly as possible.

• To follow Dental Clinics rules and regulations affecting patient care and conduct.

• To respect the rights and property of other patients and Dental Clinics personnel, including no cell phone use in the patient reception and treatment areas.

• To follow the UCSF smoke free policy.
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_______________________________________________________________________

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 _______________________

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>MI</th>
<th>Social Security Number: ____________________________</th>
<th>Date of Birth: ________________________________</th>
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<tbody>
<tr>
<td>Phone number: (     )</td>
<td>Work number: (     )</td>
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<tr>
<td>Cell number: (     )</td>
<td>Contact E-mail: __________________________</td>
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<tr>
<td>Street Address: ___________________________________</td>
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<tr>
<td>City: ___________________ State: ___________________ Zip Code: ___________________</td>
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</table>

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: _______________________

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>MI</th>
<th>Social Security #: ____________________________</th>
<th>Gender: Male  Female  Transgender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone number: (     )</td>
<td>Relationship to Patient ___________________</td>
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<tr>
<td>Insurance Name: ____________________________ Group number ____________________________</td>
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<td>Policy Number: ____________________________ Effective Date: ____________________________</td>
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<tr>
<td>Mailing Address: ____________________________</td>
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</table>
Consents/Cultural Considerations

1. Do you sign your own consents for health care?  
   a. If you are completing these forms for the patient, please print your name and state  
      your relationship to the patient? (Specify) ____________________  
   Y N

2. Which languages do you speak? _____________________________  
   Y N

3. Do you have any personal or cultural health beliefs that are important for us to know?  
   a. If yes, please specify: __________________________________________  
    Y N

4. In case of an emergency, whom should we contact? (Name) ____________________  
   a. What is his/her phone number? (Specify) _____________________  
    Y N
   b. Relationship to patient?  Spouse ____  Legal Guardian ____  Son ____  
      Daughter ____  Other (Specify) _______________  

Medical History

5. Has there been a change in your general health within the last year or since your last visit?  
   a. If yes, please specify: __________________________________________  
    Y N

6. When was your last complete medical examination? Specify Year _________  Do not remember____  
   Y N

7. Have you had any illness, condition or accident that required surgery or hospitalization  
   in the past 2 years?  Y N  
   a. If yes, please specify: __________________________________________  

8. Do you have any surgery or hospitalization planned? If yes, please specify______________________  
   Y N

9. Do you currently have a physician or primary care doctor?  
   a. Name, Location and Phone Number: _______________________________  
   Y N

10. Do you have any medical problems requiring ongoing care and monitoring?  
    a. If yes, please specify:___________________________________________  
       Y N

Illnesses:

Do you have or had in the past any of the following?  

11. Blood Disease, Condition, or Bleeding disorder?  
    o Anemia  Y N  
    o Bleeding Disorder (Specify) _________________________  o Multiple myeloma  
    o Deep vein thrombosis  o Sickle cell disease  
    o Leukemia (Specify type) _________________________  o Von Willebrand’s disease  
    o Lymphoma (Specify type) _________________________  o Other (Specify) _________________________  

12. Cancer or Tumor?  
    o Benign or Malignant (Specify) _________________________  
    o Location of tumor (Specify) _________________________  
    o Date of diagnosis _________________________  
    o Type of treatment (Specify) _________________________  
     □ Surgery  Y N  
     □ Radiation  Y N  
     □ Chemotherapy  Y N  
    o Other (Specify) _________________________
13. **Eating Disorder?**
   - Anorexia
   - Bulimia
   - Other (Specify) ____________________________

14. **Emotional disorders?**
   - ADD/ADHD
   - Anxiety
   - Bipolar/Manic-depressive
   - Depression
   - Post-traumatic stress disorder
   - Schizophrenia
   - Other (Specify) ____________________________

15. **Endocrine disease?**
   - Adrenal gland disorder (Specify) ____________
   - Type 1
   - Type 2
   - Gestational
   - Thyroid problems
   - Hyperthyroidism
   - Other (Specify) ____________________________

16. **Gastrointestinal (stomach, intestine, or colon)?**
   - Acid reflux (GERD)
   - Ulcers
   - Other (Specify) ____________________________

17. **Heart Disease?**
   - Angina (chest pain)
   - Arrhythmia (irregular heart beat)
   - Artificial heart valves
   - Congenital heart defect
   - Coronary heart disease
   - Endocarditis
   - Heart attack: Date(s) ______________________
   - Heart failure
   - High blood pressure (hypertension)
   - Implanted defibrillator
   - Low blood pressure
   - Mitral valve prolapsed
   - Pacemaker
   - Rheumatic heart disease
   - Other (Specify) ____________________________

18. **Infectious disease?**
   - Methicillin-Resistant Staphylococcus Aureus (MRSA)
   - HIV
   - What is your CD4 (T-cell) count? (Specify) ______
   - What is your viral load? (Specify) __________
   - Human Papillomavirus (HPV)
   - Immunosuppression
   - Oral herpes
   - Mononucleosis
   - Syphilis
   - Other (Specify) ____________________________

19. **Kidney disease or disorder?**
   - Renal failure/insufficiency
   - Other (Specify) ____________________________

20. **Liver disease such as cirrhosis or hepatitis?**
   - Cirrhosis
   - Hepatitis (Circle one)   A   B   C   D
   - Other Hepatitis (Specify) ____________
   - Other (Specify) ____________________________

21. **Lung, breathing or sinus problems, respiratory diseases or conditions?**
   - Asthma
   - Bronchitis
   - Emphysema
   - Pneumonia
   - Sleep apnea
   - Sinusitis
   - Tuberculosis
   - Other (Specify) ____________________________
22. Muscle/bone/connective tissue disease or disorder? Y N
   o Arthritis (Specify type) ______________  o Osteoporosis
   o Fibromyalgia
   o Lupus
   o Osteonecrosis
   o Scleroderma
   o Sjogren's Syndrome
   o Other (Specify) ______________

23. Neurologic (nerve) diseases or conditions? Y N
   o Dementia/Alzheimer's
   o Multiple sclerosis
   o Nerve pain (Specify) ______________
   o Parkinson's disease
   o Stroke
   o Seizures/Epilepsy
     □ Grand mal
     □ Petite mal
     □ Other (Specify) ______________
   o TIA (transient ischemic attack)
   o Other (Specify)

24. Organ transplant? Y N
   o Date: _______________
   o Which organ(s)? ____________________
   o Other (Specify) ____________________

25. Prosthetics (artificial) joints, knees, or hips? Y N
   o Knees
   o Hips
   o Other (Specify) ______________

26. Are you trying to become pregnant? Y N
27. Are you currently pregnant? Y N
   If yes, number of weeks pregnant? _______  Expected due date? _______
28. Are you currently breastfeeding? Y N

MEDICATIONS
29. Do you take any prescribed medications? Y N
   Please list all prescribed medications including dose and frequency ____________________
   ____________________
   ____________________
   Please list all over the counter vitamins, supplements or herbal remedies ______________
   ____________________
   ____________________

ALLERGIES
30. Are you allergic or had a bad reaction to any of the following? Y N
   o Antibiotics (Specify antibiotic and reaction) ____________________
   o Local anesthetics (Specify anesthetic and reaction) ________________
   o Latex (rubber) (Describe reaction) ______________________________
   o Metals (Specify metal and reaction) ______________________________
   o Pain medications (Specify medication and reaction) ________________
   o Other medications (Specify medication and reaction) ________________

SOCIAL HISTORY
31. Do you use or have you used tobacco (smoking, snuff, chew, bidis)? Y N
   Past Use (Check all that apply)
   o Bidis Specify amount per day _____ How many yrs? _____ When did you stop? _____
   o Chewing tobacco Specify amount per day _____ How many yrs? _____ When did you stop? _____
   o Smoking Specify amount per day _____ How many yrs? _____ When did you stop? _____
   o Snuff Specify amount per day _____ How many yrs? _____ When did you stop? _____
Currently Using (Check all that apply)
- Bidis  Specify amount per day: ___________  How many yrs? _____________
- Chewing tobacco  Specify amount per day: ___________  How many yrs? _____________
- Smoking  Specify amount per day: ___________  How many yrs? _____________
- Snuff  Specify amount per day: ___________  How many yrs? _____________

32. Are you interested in stopping tobacco use?  
   Y  N

33. Do you drink alcoholic beverages?  
   Y  N
- How many drinks do you typically have in a day? ________________
- How many drinks do you typically have in a week? ________________
- Have you received treatment for alcohol dependence condition?  
   Y  N

34. Are you interested in stopping alcohol abuse?  
   Y  N

35. Do you use prescription drugs, street drugs or other substances for recreational purposes?  
   Y  N
- Cocaine (Specify frequency) ____________  o  Heroin (Specify frequency)
- Ecstasy (Specify frequency) ____________  o  Oxycontin (Specify frequency) ____________
- Marijuana (Specify frequency) ____________  o  Other (Specify frequency) ____________
- Methamphetamine (Specify frequency) __________

36. Are you interested in stopping drug abuse?  
   Y  N
UCSF SCHOOL OF DENTISTRY
Dental-Related History Form

CONFIDENTIAL

Date: ___________

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?
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?___________________________________________