UCSB Student Health Service Confidential Dental History
Tel: (805) 893-2891

PATIENTS DENTAL HEALTH

Patient Name:_____ **Date:**_____
Last **First**

Preffered Name (if any):_____ **Pronouns:**_____

Perm:_____ **DOB:**_____ **Grad or Undergrad student?**_____

Address:_____

Phone:_____ **Email:**_____

Why have you come to see us today (e.g: pain, checkup, etc.):_____

Last Visit:_____ **Date of last cleaning:**_____ **Have you had problems with past dental treatment? Y☐ N☐**

Are you nervous about seeing a dentist? Y☐ N☐ If yes, please tell us why:_____

How often do you brush?_____ **Do you floss? Y☐ N☐ If yes, How often?**_____

Y☐ N☐ I clench or grind my teeth during the day or while sleeping.
Y☐ N☐ My gums bleed while brushing or flossing.
Y☐ N☐ I avoid brushing part of my mouth due to pain.
Y☐ N☐ My gums feel tender or swollen.
Y☐ N☐ I have had orthodontics/braces.
Y☐ N☐ I have had a facial or jaw injury.
Y☐ N☐ I want my teeth whiter.

PATIENTS MEDICAL HISTORY

Do you have or have you had any of the following? Please check Y for yes or N for No.

Y☐ N☐ Heart Disease
Y☐ N☐ Heart Murmur/Mitiral Valve Prolapse
Y☐ N☐ Stroke
Y☐ N☐ Congenital Heat Lesions
Y☐ N☐ Rheumatic Fever
Y☐ N☐ Pacemaker
Y☐ N☐ Stent
Y☐ N☐ Abnormal Blood Pressure
Y☐ N☐ Anemia
Y☐ N☐ Prolonged Bleeding Disorder
Y☐ N☐ Tuberculosis or Lung Disease
Y☐ N☐ Asthma
Y☐ N☐ Hay Fever
Y☐ N☐ Sinus Trouble
Y☐ N☐ Epilepsy/Seizures
Y☐ N☐ Ulcers
Y☐ N☐ Liver Disease
Y☐ N☐ Jaundice
Y☐ N☐ Hepatitis Type_____
Y☐ N☐ Diabetes
Y☐ N☐ Excessive Urination and/or Thirst
Y☐ N☐ Infectious Mononucleosis (Mono)
Y☐ N☐ Herpes
Y☐ N☐ Arthritis
Y☐ N☐ Sexually Transmitted/Venereal Diseases
Y☐ N☐ Kidney Disease
Y☐ N☐ Tumor or Malignancy
Y☐ N☐ Cancer/Chemotherapy
Y☐ N☐ Radiation/Therapy
Y☐ N☐ History of Drug Addiction
Y☐ N☐ Hypothyroidism
Y☐ N☐ Hyperthyroidism
Y☐ N☐ HIV
Y☐ N☐ AIDS
Y☐ N☐ Immune Suppressed Disorder
Y☐ N☐ Hearing Loss
Y☐ N☐ Fainting Spells
Y☐ N☐ Glaucoma
Y☐ N☐ History of Emotional or Nervous Disorders
Y☐ N☐ History of Eating Disorders
Y☐ N☐ Are you taking birth control medication?
Y☐ N☐ Are you or could you be pregnant or nursing?
Y☐ N☐ Implants/Artificial Joints: Hip-Knee_____ Other_____
Y☐ N☐ I smoke or use chewing tobacco. If yes, how much per day?_____ How many years?_____
Y☐ N☐ I have consumed alcohol within the last 24 hours.
Y☐ N☐ I usually take an antibiotic prior to dental treatment.
Y☐ N☐ Have you ever taken Fen-Phen or Redux?
Y☐ N☐ I have had major surgery. Year_____ Type of operation_____ Year_____ Type of operation_____
Y☐ N☐ Do you have any other medical problems or medical history not listed on this form?_____

Are you allergic to the following?

Y☐ N☐ Aspirin
Y☐ N☐ Ibuprofen
Y☐ N☐ Sulfa Drugs/Sulfites/Sulfides
Y☐ N☐ Penicillin
Y☐ N☐ Codeine
Y☐ N☐ Latex, Metals, Plastics
Y☐ N☐ Local Anesthetics (i.e., Novocain, Lidocaine)
Y☐ N☐ Other Medications Which ones? _____

Please list all medications you are currently taking:

Medicine_____ Condition_____
Medicine_____ Condition_____
Medicine_____ Condition_____
Medicine_____ Condition_____

In the event of an emergency please contact:

Name:_____ Relationship:_____ Phone:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ **Date**_____
Signature of patient, parent or guardian

I give consent for the Dentists/Hygienists at UCSB Dental Care Center to treat my dental needs. I understand that treatment recommended to me is only an estimate and may change in the process of treatment.

I authorize the Dentist to choose the dental material that best suits my dental needs. I also understand that I may ask questions about the dental materials used in the Dental Care Center.

I understand there is a 24 hr. cancellation policy. If I cancel less than 24 hrs. prior to my dental appointment, there will be a $25 late cancelation fee. If I miss an appointment altogether, I will incur a $55 missed appointment fee.
I have read the above conditions of treatment and agree to their content.

_____ **Date**_____
Signature of patient/Responsible party