

PATIENT REGISTRATION:

Please complete at each appointment so that we can update your information.

First Name: _____ Last Name: _____

Please circle: Male or Female

Address: _____ Date of birth: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____

Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No _____

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Women: Are you

Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs

Other If yes, please explain: _____

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

AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Angina	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Rheumatism	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Spina Bifida	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No
Breathing Problem	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Genital Herpes	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Convulsions	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No	Venereal Disease	<input type="radio"/> Yes <input type="radio"/> No
						Yellow Jaundice	<input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed above? Yes No _____

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

University of Arkansas for Medical Sciences

Dental Hygiene Clinic

The dental hygiene clinic (Clinic) of UAMS is a teaching facility designed to provide clinical education and experience to dental hygiene students while providing high quality preventive dental hygiene care to patients. Because teaching students is the primary responsibility of the Clinic, we would appreciate your patience and cooperation in assisting us in our efforts.

Clinic Policies

Appointments

- Appointments are scheduled for approximately 2 to 2 1/2 hours in length.
- We request your cooperation in appearing on time for your scheduled appointments.
- Depending on individual needs, several appointments may be necessary to complete treatment.
- We request your cooperation in appearing on time for your scheduled appointments. If you are more than 15 minutes late, your appointment may have to be rescheduled for another day.
- Please provide at least 24 hours notification if unable to keep dental appointment.
- If you do not appear for your appointment and haven't given us a notice then it will be considered a *broken appointment*. Broken appointments could result in your dismissal as a patient in our clinic. Habitual cancellations which are 3 or more could potentially result in dismissal from our clinic.
- Patients are to park in the UAMS Patient and Visitor parking decks. The Clinic does not pay for parking expenses.

New Patients

In the interest of providing comprehensive care to our patients, the UAMS Dental Hygiene Clinic will provide all new patients over the age of 18 years an appointment for a "New Patient Evaluation" which will include the following:

- Medical history review
- Intra/Extraoral examination
- Dental charting and examination by the supervising dentist
- An evaluation of your periodontal condition (gum disease) will be completed.
- Appropriate radiographs (x-rays) as determined by individual needs
- Examination by the dental hygiene instructor
- Individualized patient education
- Oral hygiene instructions
- Treatment planning
 - The approximate cost of your treatment and approximate number of appointments needed will be explained at this time.
 - If you require advanced periodontal (gum disease) treatment, several appointments may be required to complete your care.
 - Treatment alternatives, expected outcomes of treatment, and risks of no treatment will be discussed with you.
- The cost for this service is \$30.00 which includes x-rays.

- NO cleaning will be performed at this time. As outlined in the treatment plan developed, you will be reappointed for the appropriate type and number of appointments.

X-rays

- X-rays are a necessary part of your diagnosis and treatment; therefore, current x-rays are required of all patients.
- The type of x-rays prescribed by the dentist will be based upon your individual needs.
- Updated x-rays can be taken here or mailed to us from your dental office.
- If taken here, the x-rays can be mailed to your dentist upon your request after they have been evaluated/graded by the supervising dentist (usually 1-3 day time frame).
- Refusal to have x-rays taken or provide current x-rays from your dentist's office will prevent us from being able to see you in our clinic as x-rays are necessary for the best patient care.

Infection Control

- For your protection, all dental instruments are sterilized and dental units are disinfected after each patient.
- Students and faculty are required to wear masks, gloves, and glasses during patient treatment.
- The Department of Dental Hygiene maintains the infection control guidelines of the Centers for Disease Control and Prevention (CDCP) and the Occupational Safety and Health Administration (OSHA).

Payment

- Payment of services is due at the time treatment is provided.
- Because we do not bill for services, payment must be made by credit/debit cards or check only.
- You will be given a receipt for services and fees. Fees for services are posted in the reception area.

Children and Minors Under 18

- All minors must have the medical history and consent for treatment signed by a parent or guardian prior to treatment.
- No children are allowed in the clinic area unless being treated as a patient.
- Our clinic is not equipped to provide child care or babysitting services. Please make proper arrangement to have your children properly supervised when you are receiving treatment.

Cellular Phones

The operation or use of cellular phones in the clinic is prohibited. We ask all patients to turn **OFF** or place your device on **MUTE** while in the clinic area. Students are not allowed the use of such devices in order to focus on your treatment. Therefore, we ask that you return the same respect to our students and faculty by refraining from making or receiving phone calls or text messages in the clinic.

UAMS Dental Hygiene Clinic Patient Rights

- As a patient, you have the right to considerate and high quality dental hygiene care appropriate to your needs.
 - All treatment will be rendered under the supervision of UAMS faculty members and meet the highest standards recognized by the dental hygiene profession for practice.
 - The UAMS Dental Hygiene Clinic does not discriminate on the basis of age, sex, race, or handicapping condition. Should you require special care due to a hardship, please inform our staff.
 - After a comprehensive oral examination you will be informed of your oral health status and treatment needs.
 - You have the right to refuse any or all treatment at which time you may be referred for treatment elsewhere.
 - Upon your acceptance of the recommended treatment, it is your responsibility to make your scheduled appointments and complete the treatment planned for you.
 - The treatment performed may not constitute full and comprehensive dental care. Should you require additional dental care, you will be provided a referral letter of the treatment needed in order that you may seek dental care from the dentist of your selection.
- ❖ My signature below indicates that I have received a copy of the UAMS Dental Hygiene Clinic Policies and Patient Rights Statement, and that I have read these policies and agree to follow by the stated policies of the UAMS Dental Hygiene Clinic with regard to:
- Appointment length, broken appointments, parking
 - New patient evaluation appointments
 - X-rays
 - Infection control standards
 - Payment
 - Treatment of minor patients

Signature: _____ Date: _____

Consent for Treatment

- I have received, read, and signed the UAMS Notice of Privacy Practices form.
- I understand that the care provided is primarily preventive in nature and does not constitute comprehensive dental care.
- I understand that all diagnostic aids, including radiographs and/or photographs are the property of the Clinic.
- I further authorize the administration of such anesthetics and medications as are considered necessary for my treatment.
- I hereby give my consent for my initial care and all subsequent care to the faculty and students of the Department of Dental Hygiene to provide any and all necessary diagnostic and dental hygiene services for myself or, my child, (child's name _____) unless affirmatively revoked in writing.
If child, relationship to patient: _____

Signature: _____ Date: _____

(Place MR Label Here)

MR#:
Patient's Name:
Patient's Address:



Acknowledgment of Receipt of Privacy Notice

By signing this form, you are only agreeing that you have received a copy of the UAMS Notice of Privacy Practices.

Patient Signature

Date/Time

Print Legal Representative's Name (if applicable)

Legal Representative's Signature

If Legal Representative, authority of Legal Representative (such as parent of a minor, guardian, administrator of estate of deceased, attorney-in-fact appointed with power of attorney, or healthcare proxy)

STAFF USE ONLY

We provided the Notice of Privacy Practices and attempted to obtain written acknowledgment but acknowledgment could not be obtained because:

- Patient or Legal Representative declined to sign the Acknowledgment of Receipt.
Other (please specify)

Printed Name of Employee Completing Form

Date/Time

Signature of Employee Completing Form

UAMS Location

