

Patients desiring to be considered for treatment in the adult student clinics (13 years old or older) need to apply for a screening appointment.

The screening appointment will be a brief examination by a faculty member to determine if your needs are compatible with the educational needs of our students. The necessary x-rays will be taken at this appointment. There is a fee of \$90.00 for the examination and the x-rays. All fees are due at the time service is provided. Patients who are not accepted into the student clinics will be referred to the UF College of Dentistry Faculty Practice, a specialty program, or be advised to go to private practice.

Once your screening appointment and X-rays are completed, you will be referred to Patient Assignment. Your assignment to a student dentist is based on your potential treatment needs, not on the date you were screened. When an appropriate student is available, you will be assigned. The average time between screening and assignment to a student is two months. Once assigned, the student will contact you and arrange for an appointment to develop a detailed plan and begin treatment.

The fees in the student program generally are 50% less than those in private practice. You will be required to pay for routine care each time you come. For more extensive treatment, such as crowns or dentures, payment plans may be arranged.

To insure the safety of children, they will not be allowed to accompany you into the treatment area or be left unattended in the waiting area. Please arrange appropriate childcare.

Patients are not assigned to students if they have outstanding balances from prior treatment in the College of Dentistry.

- Are 12 Years old or younger, please contact our [Pediatric \(Children's\) clinic](#) at 352.273.7643.
- Are from outside Gainesville, you may want to visit one of our [Satellite Clinics](#)
- Want [Orthodontic treatment \(braces\)](#) please call 352.392.4285
- Need wisdom teeth extracted (third molars), contact Oral Surgery at 352.273.6731
- Are in pain, visit [Student Oral Surgery Clinic](#)

UNIVERSITY OF FLORIDA - COLLEGE OF DENTISTRY

Patient Registration Form

Chart Location: _____ **Chart Number:** _____ **Dr. Assigned:** _____ **Date:** _____

PATIENT INFORMATION				
Patient Last Name		First Name		Middle Name
Mailing Address including Apt #		Guardian Name (If patient is 18 years or younger) C/O		
City, State, Zip			County	(Circle One) MALE FEMALE
(Circle One) EMPLOYED Full-Time STUDENT Part-Time STUDENT		Employer Name and Name of School Attending		
Home Telephone Number Area Code ()		Work Telephone Number Ext. Number Area Code ()		
Date of Birth	Social Security Number		Driver's License Number + State	
(Circle One) SINGLE MARRIED OTHER _____				
Ethnic Origin (Circle One) Asian - A	African American - B Native Hawaiian - J	Caucasian/White - C American Indian - I	Hispanic - H Alaskan Native - I	Pacific Islander - P Other _____
EMERGENCY CONTACT INFORMATION				
Name		Telephone Number		Relationship to Patient
Address				
City			State	Zip

The optional demographic and financial information is being asked to better understand the patients served by the College of Dentistry. This information is used to request additional funds from the government and other sources, to help keep the cost of dental care affordable for our patients.

Number in Household (Circle one) 1 2 3 4 5 6 7 8 9 10 or More	GROSS Annual Household Income \$ _____ Per YEAR (Ex. \$20,000 = 20000)
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PLEASE NOTE: The College of Dentistry only accepts a LIMITED number of insurance plans. Please ask if we accept your plan BEFORE completing this next section.

PRIMARY INSURANCE COVERAGE			
Name of the Insured Person as it reads on your card		Date of Birth	SEX (Circle) MALE FEMALE
Address of Insured Person		City	State Zip
Telephone Number		Social Security Number Driver's License Number/State	
Name of Insurance Company		Insured Identification Number Group Name or Number	
Address of Insurance Company		City	State Zip
SECONDARY INSURANCE COVERAGE			
Do you have Secondary Insurance Coverage? YES NO		If yes, please provide copy of your insurance card.	

INTERNAL USE ONLY Updated: YES NO Date Completed: _____ Changes Made By: User# _____ Initials _____



UNIVERSITY OF
FLORIDA

College of Dentistry

HEALTH QUESTIONNAIRE

Time Preference					
	M	T	W	TH	F
7:30 A.M.					
1:00 P.M.					

PATIENT NAME	CHART NUMBER

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CHECKING THE APPROPRIATE BOX.

YES	NO	
		1. Have you been told that you have heart trouble? A heart murmur?
		2. Have you ever been told that you have tuberculosis (TB)?
		3. Have you ever been told that you have high or low blood pressure?
		4. Have you ever had a stroke? When?
		5. Have you ever been told that you have asthma?
		6. Have you had an "implant" surgery (prosthetic hip, heart valve, other)?
		7. Have you ever had rheumatic fever? A prolapsed mitral valve?
		8. Have you ever had jaundice, liver trouble or hepatitis?
		9. Have you ever been told you have kidney or bladder trouble?
		10. Have you had any sexually transmitted disease (syphilis, gonorrhea, genital herpes)?
		11. Are you HIV positive?
		12. Have you ever had anemia? Leukemia?
		13. Have you ever been told that you have diabetes or "high or low blood sugar"?
		14. Have you ever been told you have a tumor or cancer?
		15. Have you ever had excessive bleeding following tooth removal?
		16. Are you sensitive or allergic to any medicines (penicillin, sulfa drugs, aspirin, etc)?
		17. Are you allergic to any foods, metals, pollens or latex?
		18. Have you ever been told not to take novocaine or any other medication?
		19. Are you currently under the care of a physician? <u> </u>
		Doctor's name Phone number
		20. Are you currently taking any medicines? If so please list them.
		21. Are you Pregnant? Expected delivery date:
		22. Do you think you need upper or lower dentures?
		23. Do you have any special needs – such as hearing impaired, wheelchair, etc...?

I consent to the following initial (screening) examination and understand that it is being done only to determine my possible acceptance into the teaching programs of the University of Florida College of Dentistry. It is **NOT** a complete and thorough examination of the head and neck region.

Patient or Parent/Guardian Signature	Date