

HOW TO APPLY FOR A SCREENING APPOINTMENT

1. Completely fill out the screening form and print it.
2. **Fax** completed form to 352-273-7484
- OR -
Mail completed form to:
UF College of Dentistry
Records/Screening
P.O. Box 100425
Gainesville FL
32610-0425
3. Screening staff will contact you soon for an appointment.

We will attempt to call you for two months, after which you will need to re-apply.

If you are unable to print or fax the form, call 352-273-9097 or (toll free) 1.800.633.3953 opt. 3.

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	Sex M F	
Employment Status (Select One) EMPLOYED Full-Time STUDENT Part-Time STUDENT			Employer Name/Name of School Attending		
Home Telephone Number (incl. Area Code)	Work Telephone Number (incl. Area Code)	Ext.	Date of Birth (MM/DD/YYYY)		
Driver's License Number & State			Marital Status (Select One) Single Married Other		

EMERGENCY CONTACT INFORMATION

Name	Telephone Number (incl. Area Code)	Relationship to Patient
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This 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.

OPTIONAL DEMOGRAPHIC AND FINANCIAL INFORMATION

Ethnic Origin (Select One) Asian (A) African American (B) Caucasian/White (C) Hispanic (H) American Indian/Alaskan Native (I) Native Hawaiian (J) Pacific Islander (P) Other (specify)									
Number in Household (Select One) 1 2 3 4 5 6 7 8 9 10 or More							GROSS Annual Household Income \$ Per Year (e.g. \$20,000 = 20000)		

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 (MM/DD/YYYY)		Sex M F
Address of Insured Person		City	State	Zip	
Home Telephone Number (incl. Area Code)		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? Y N		If yes, please provide a copy of your insurance card.
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INTERNAL USE ONLY

Updated Y N		Date Completed	Changes Made By User#: Initials:	
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Appointment Time Preference					
	M	T	W	TH	F
Morning					
Afternoon					

HEALTH QUESTIONNAIRE

Patient Name _____

Chart Number _____

Please answer the following questions by selecting "Yes" or "No"

YES	NO	
		1. Have you ever 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 ever had "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 ever 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/lidocaine or any other medication?
		19. Are you taking or have you taken any medications for osteoporosis (Fosamax, Boniva, Actonel, etc.)?
		20. Are you currently under the care of a physician? Doctor's name: _____ Phone Number: _____
		21. Are you currently taking any medicines? If so, please list them: _____
		22. Are you pregnant? Expected delivery date: _____
		23. Do you think you need upper or lower dentures?
		24. Do you have any special needs (hearing impairment, wheelchair, etc.)? If so, please explain: _____

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 thorough and complete examination of the head and neck region.

Patient or Parent/Guardian Signature _____

Date _____