RIVERSIDE FREE CLINIC
DENTAL

Patient Registration

Personal Information

Name: _____ Gender: ☐ M ☐ F Date: _____

If Minor, Parent's Names: _____

Date of Birth: _____

Mailing Address: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact

Name: _____ Relationship: _____

Address: _____

Medical History

Yes / No Is your general health good?

Yes / No Has there been changes to your health in the past year?

Yes / No Have you been hospitalized or had a serious illness?

Allergies: _____

List current medications: _____

Yes / No Are you or could you be pregnant?

Yes / No Taking contraceptives?

Insurance

Insurance Company: _____

Policyholder Name: _____

Policy #: _____

Social Security #: ___-___-____

Do you have or have you had any of the following:

☐ Cancer or Tumor	☐ Heart Attack or chest pain (angina)	☐ Heart murmur, heart defect
☐ Rheumatic Fever	☐ Artificial joint or valve	☐ High blood pressure
☐ Pacemaker	☐ Tuberculosis or other lung problems	☐ Kidney or bladder disease
☐ Hepatitis or other liver disease	☐ Blood transfusion	☐ Diabetes
☐ Psychologic Care	☐ Epilepsy, seizures, or fainting spells	☐ Emotional condition
☐ Arthritis or rheumatism	☐ Herpes or cold sores	☐ AIDS or HIV positive
☐ Headaches	☐ Anemia or blood disorders	☐ Abnormal bleeding extractions, surgery, or trauma
☐ Hayfever or sinus trouble	☐ Allergies or hives	☐ Asthma

Yes / No Tobacco in any form?

Do you have and did you have any disease or medical condition NOT listed on this form?

Dental History

Oral Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Date of Last Dental Visit: _____ Treatment Type: _____

How often do you brush your teeth? _____ Floss? _____ Mouthwash? _____

Do you have or have you had any of the following:

Yes / No Are you currently having dental discomfort?

If yes, explain: _____

Yes / No Have you had any head, neck, or jaw injuries?

If yes, explain: _____

Yes / No Do you wear dentures or partials?

Yes / No Gums bleed when brushing or flossing?

Yes / No Concerned about gum disease or a history of gum disease?

Yes / No Does it hurt to bite or chew?

Yes / No Do you clench or grind your teeth?

Please add anything else you would like us to know about: _____

_____

My signature below indicates that I have read and understand the information on both the front and back of this page and I am willing to comply with the foregoing, and that I am patient, the parent or guardian of the patient with authority to give consent, or that I am duly authorized by the patient as the patient's general agent to execute the terms of this form. I give Riverside Free Dental Clinic and it's providers, permission to provide dental treatment for the respective patient.

Patient Name *(please print)*: _____

Patient/Parent or Guardian Signature: _____

Name of Parent/Guardian *(if applicable)*: _____

Date: _____

Witness Signature: _____

Patient Waiver:
I understand that these dental procedures will take place to collect basic information concerning health/medical history and to provide for better oral health. Any procedure/data collection will involve basic measures and/or assessment of blood pressure, height, weight, general appearance and may involve additional examinations as deemed appropriate by the persons conducting dental procedures.

I understand that any dental procedure will be conducted by medical, dental, nursing, and other health professions students of Western University of Health Sciences ("WesternU") and that the individuals that perform the procedure are not doctors, nurses, or licensed health care providers. I understand that a faculty member of WesternU will be present at the time of any given procedure to supervise the activities of the WesternU students.

I understand that any dental procedure given today will not provide any emergency medical services.

I understand that it is my sole responsibility to follow through with my personal physician/dentist and or Riverside Free Dental Clinic (RFDC) personnel on any potential concerns regarding my dental examination and to obtain medical clearance from my personal physician for any medical issues related to my health.

Treatment Plan:
I understand that the treatment plan that I accept is recommended dental treatment and that this plan could change. I understand that I am encouraged to ask my dentist questions about the procedures recommended. All dental procedures may involve risks and no guarantees are made to any treatment outcomes. As the patient, or parent or guardian, I have the right to consent or refuse any proposed procedures at any time. RFDC also reserves the right to not perform specific treatment requested by a patient. I understand that there will be no cost for dental care.

After Hours Emergency Care:
If an emergency or postoperative complication, I should call (951) 374-0325 to reach a dental student. I can also refer to the list of the dental clinics in the area for assistance. If I am experiencing bleeding that will not stop or any life threatening emergency, I will go directly to my local emergency room.

Health:
If I have any changes in my health status, changes in my medications or any recent hospitalizations, I will inform RFDC. If I am taking a type of drug called bisphosphonates, I will inform RFDC as I may be at risk of developing osteonecrosis (bone death) of the jaw and certain dental treatments may increase that risk.

Dental Records:
I understand that the dental records and X-rays and any other diagnostic aids that relate to my treatment here, are the property of RFDC. I acknowledge that I have the right to inspect these records and/or receive a copy of them or to request that they be sent to another health care provider. In order to obtain a copy of my records I will need to complete and sign a Release of Information form.

Images:
I give RFDC the right to use all audio and/or visual images captured during clinic for any educational, advertising, trade, promotional, or other lawful purpose related to RFDC. I agree that RFDC owns the copyright for these images and I waive all claims of invasion of privacy for defamation.

Consent:
I consent to examination, X-ray and diagnostic testing for the development of my proposed treatment plan and I further consent to any treatment procedures, which are diagnosed and indicated on the treatment plan. I agree that all records are the property of RFDC.

Release of Liability:
I have read and I understand the acknowledgments set forth above. I hereby release Western University of Health Sciences and its affiliated entities, and all of their respective faculty, students, agents, employees and representatives, from any and all liability which may arise from a screening/dental procedure, and/or from any information provided to me by Western University of Health Sciences or any of its faculty, students, agents, employees, in connection with the dental procedure.

Patient Signature: _____ **Date:** _____

Clinic Personnel Use Only

Changes To Medical History		Student Doctor Signature	Date
Yes	No		
☐	☐	_____	_____
☐	☐	_____	_____
☐	☐	_____	_____
☐	☐	_____	_____
☐	☐	_____	_____