Dear Patient:

We are proud that you've chosen the UCLA Faculty Group Dental Practice for your dental care. Our dental practitioners, who are also faculty at the UCLA School of Dentistry, provide a full range of preventative services and dental treatments in our private practice setting.

What to bring to your first appointment
If you can get access to recent dental X-rays (originals, not copies, from the last two years) we may not need new X-rays.

Directions and parking
From the 405 freeway, take the Wilshire Boulevard East exit to Westwood Boulevard. Turn left on Westwood, and continue until you reach UCLA Medical Plaza (just north of Le Conte Avenue). Turn left into UCLA Medical Plaza. Underground parking ($12) is available beneath our office at 100 UCLA Medical Plaza.

Payment and Insurance

- General Dentists
- Pediatric Dentists
- Orthodontists
- Endodontists
- Oral and Maxillofacial Surgeons
- Periodontists
- Delta Dental Premier Providers - Patient portion (copay) due at time of service
- Other indemnity / PPO program:
- Payment in full due at time of service - Faculty Group Dental Practice will help facilitate your reimbursement at out-of-network rates
- HMO plan (including Delta PMI) are not accepted
- Prosthodontists
- Not Delta Dental Premier Providers

Questions?
Please contact us at (310) 794-5750 or email FGDP@dent.ucla.edu. We're here to help.

We look forward to taking care of your oral health needs.
UCLA FACULTY GROUP DENTAL PRACTICE REGISTRATION

Patient Account Number ____________________________ Date ____________

PATIENT PERSONAL DATA

(Please Print)

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>Middle</th>
<th>Title</th>
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</table>

Patient Address

<table>
<thead>
<tr>
<th>Number</th>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
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Guarantor Name

(Person to Pay Faculty Group Dental Practice)

<table>
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<th>Number</th>
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Billing Address

(if different from above)

<table>
<thead>
<tr>
<th>Number</th>
<th>Street</th>
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Home Phone (_____) — — —

Work Phone (_____) — — —

Social Security Number — — —

Birthday — / — / —

Sex ☐ M ☐ F ☐ Single ☐ Married ☐ Child

Driver’s License Number — — —

Medical Physician’s Name — — —

Referred by — — —

Address

<table>
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<tr>
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Chief Complaint — — —

Medical Alert ☐ No ☐ Yes

Nearest Friend/Relative (Not Living at Your Address)

<table>
<thead>
<tr>
<th>Number</th>
<th>Street</th>
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Type: — — —

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Phone Number (_____) — — —

Relationship to Patient — — —

INSURANCE AND FINANCIAL DATA

Patient’s Employer — — —

Patient’s Occupation — — —

Employee Address

<table>
<thead>
<tr>
<th>Number</th>
<th>Street</th>
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<th>Zip</th>
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</table>

Do You Have Dental Insurance? ☐ No ☐ Yes If Yes, Please Complete the Following: Date of Birth — / — / —

Primary Insurance Company

Employee Name — — —

Employee Address

<table>
<thead>
<tr>
<th>Number</th>
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</table>

Social Security Number — — —

Employee ID # — — —

Employee DOB — / — / —

Employer Relationship to Patient — — —

Employer Name — — —

Employer Phone Number (_____) — — —

Employer Address

<table>
<thead>
<tr>
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</table>

Insurance Company Name — — —

Insurer Co. Phone Number (_____) — — —

Insurance Co. Address — — —

Group # — — — Local # — — — Policy # — — —

Secondary Insurance Company (if applicable)

Employee Name — — —

Employee Address

<table>
<thead>
<tr>
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Social Security Number — — —

Employee ID # — — —

Employee Relationship to Patient — — —

Employer Name — — —

Employer Phone Number (_____) — — —

Employer Address

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</table>

Insurance Company Name — — —

Insurer Co. Phone Number (_____) — — —

Insurance Co. Address — — —

Group # — — — Local # — — — Policy # — — —
UCLA Dental Center

HEALTH QUESTIONNAIRE

Name

Physician's Name

Address

Dentist's Name

Address

Birth Date

Phone (1)

Date Last Visit

City

State/Zip

City

State/Zip

Major dental problem or reason for coming to the UCLA Dental Center

1. Have you had an unexplained gain or loss of weight (past 6 months)? How much? Yes No
2. Do you smoke or use tobacco? If Yes, how much? Yes No
3. Do you drink alcoholic beverages? If Yes, how much? Yes No
4. Have you ever been treated for cancer? Yes No
5. Have you ever had radiation treatment? Yes No
6. Do you have a poor appetite? Yes No
7. Do you sleep poorly or use medications to sleep? Yes No
8. Do you feel that you are currently more tired than usual? Yes No
9. Do you have many body aches and pains? Yes No
10. Do you have night sweats or recurring fever? Yes No
11. Have you ever used intravenous drugs? Yes No
12. Have you used cocaine or "crack" within the past 6 months? Yes No
13. Do you actively engage in high risk behavior for infectious diseases (e.g., AIDS, hepatitis)? Yes No
14. Please describe your general health

Do you have or have you ever had:

HEAD AND NECK

Yes No
15. Recurrent headaches
16. Glaucoma / eye disease
17. Recurrent earaches / hearing problems
18. Chronic sinusitis / post-nasal discharge
19. Recent difficulty swallowing
20. Persistent sore throat and hoarseness
21. Swollen neck glands
22. Recurrent neckache or neck pain
23. Injury to head, neck, jaw, teeth

DENTAL

Yes No
24. Chronic face pain/jaw pain
25. Clefting / popping jaw
26. Difficulty opening or closing jaw
27. Unable to chew food well
28. Blisters / sores on lips or mouth
29. Unpleasant taste / bad breath
30. Burning tongue / lips
31. Swelling / lumps in mouth
32. Bleeding or infected gums
33. Loose teeth
34. Pain when chewing or opening mouth
35. Bothersome catching of food between teeth
36. Recent toothache / sensitivity
37. Uncomfortable bite
38. Recent need to chew on one side
39. Clenching / grinding
40. Your bite adjusted
41. Bite appliance (TMJ splint)
42. Gum treatment or surgery
43. Orthodontic treatment (braces)

Do you have or have you ever had:

NEUROMUSCULAR SYSTEM

Yes No
44. Fainting spells or loss of consciousness
45. Seizures
46. Numbness, tingling, or paralysis
47. Muscle weakness / multiple sclerosis
48. Recurrent backaches
49. Problem / walking, balance, dizziness
50. Persistent stiffness or painful joints
51. Artificial bone or joint implants
52. Recent or unusual headaches

REPRODUCTIVE

Yes No
53. Breathing problems
54. Asthma or emphysema
55. Tuberculosis or a persistent cough
56. Coughed up blood
57. Pneumonia

CARDIOVASCULAR

Yes No
58. High blood pressure
59. Awaken with breathing difficulty
60. Difficulty breathing when lying down
61. Swollen ankles
62. Irregular or rapid heart beats
63. Chest pain due to physical exertion
64. Chest pain when upset
65. Rheumatic heart disease or fever
66. Congenital heart disease / heart murmur
67. Prolapsed heart valve
68. Cardiac or vascular surgery
69. Heart attack and/or angina
70. Other heart problem
71. A stroke

PLEASE TURN OVER
UCLA Dental Center

HEALTH QUESTIONNAIRE

Do you have or have you ever had:

GASTROINTESTINAL / GENITO-URINARY

72 Persistent diarrhea / odd colored stools
73 Colitis or ulcers
74 Unexplained vomiting / frequent nausea
75 Alcoholic liver disease
76 Hepatitis or other liver disease
77 Jaundice (yellow skin or eyes)
78 Awaken more than twice a night to urinate
79 Kidney disease / renal dialysis
80 Kidney transplant
81 Any urinary infection
82 Syphilis
83 Gonorrhea
84 Any other sexually transmitted disease

Yes No

HEMA / ENDO / IMMUNE

90 Bruise easily / bleed excessively after a cut
91 A blood transfusion
92 Anemia or denied permission to give blood
93 Leukemia (cancer of the blood)
94 Diabetes or been frequently thirsty
95 Thyroid or adrenal gland disease
96 AIDS or ARC (AIDS Related Complex)
97 Positive blood test for HIV antibodies
98 Skin blotsches or rash
99 Rheumatoid arthritis
100 Chronic itching

WOMEN ONLY

Yes No

ALLERGIES

85 Penicillin
86 Sulfa drugs
87 Dental anesthetics
88 Metal (rings / earrings)
89 Other (specify)

Have you been allergic to or had a bad reaction to:

101 Do you menstruate regularly?
102 Do you flow heavily?
103 Are you now pregnant?
104 If so, please give due date
105 Are you in or have you passed through menopause (change of life)?
106 Are you taking hormones?
107 Are you taking birth control pills?

Has anyone in your family (grandparent, parent, sibling, child) ever had:

FAMILY HISTORY

108 Bleeding disorder
109 Heart disease
110 Mental / emotional disorders
111 Any genetic diseases / illnesses (please specify)

BEHAVIORAL

115 Are you available and able to sit for a three-hour dental appointment?
116 Are there some aspects of the appearance of your teeth and jaw that need to be changed?
117 Do you often feel depressed or moody?
118 Do you often feel anxious or nervous?
119 Have you ever had psychiatric or psychological counseling?
120 Did you ever avoid a dental appointment because you were frightened?
121 Do you ever feel uncomfortable asking questions of doctors?

List all prescription and non-prescription drugs (including aspirin) taken within the past 6 months:

Name
Dosage
Doseage
Name
Dosage

1. ___________________________ 3. ___________________________
2. ___________________________ 4. ___________________________
5. ___________________________

Please list all hospitalizations and emergency room visits (include dates and reasons):

1. ___________________________
2. ___________________________
3. ___________________________
4. ___________________________
5. ___________________________
6. ___________________________

122 Have you been dissatisfied with previous dental treatment? Yes No

If Yes, please describe:

I have read and understood the above questionnaire and have answered all questions truthfully to the best of my ability. If ever my health or medications change, I will inform my dentist at my next appointment.

Patient Signature: ___________________________ Date: ____________
Guardian: ___________________________ Date: ____________

C 6 (11/93)
Due to a strong desire to keep your dental cost as low as possible by reducing overhead, we have implemented the following policies. Please read the policies, and sign below where indicated.

**FINANCIAL POLICY**

Patients of the Faculty Group Dental Practice are required to pay each visit for services rendered. However, patients with Delta Dental Insurance coverage are required to pay the patient portion only at each visit for services rendered. It is the patient's responsibility to request the estimated charges for subsequent appointments. We will be happy to charge your account on Visa, MasterCard, American Express or Discover.

**INSURANCE POLICY**

1. **Claim Processing.** It is the patient's responsibility to advise the Faculty Group Dental Practice Business Office of any insurance coverage or insurance coverage changes. For the convenience of our patients, Delta Dental Insurance claim forms will be processed upon completion of treatment. All other insurance claim forms will be processed upon request.

2. **Pre-Authorizations.** Patients may request a pre-authorization from their insurance company for their treatment. When we have received a written pre-authorization from the insurance company, we will require payment of the entire patient portion at the start of treatment.

3. **Laboratory Procedures.** Treatment requiring laboratory procedures, i.e., crowns, bridges, dentures, partial dentures, splints, bite guards, etc. – For patients with insurance other than Delta Dental Insurance, all treatment requiring laboratory procedures must be paid for in full prior to delivery. Delta Dental Insurance patients having treatment requiring laboratory procedures will be required to pay the patient portion at the start of treatment.

**CANCELLATION**

If unable to keep an appointment, please give 24 hours notice. Failure to give 24 hours notice for cancellation or failure to show for an appointment will result in the following fees:

<table>
<thead>
<tr>
<th>Hygiene appointment</th>
<th>$50.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental appointment</td>
<td>$100.00</td>
</tr>
</tbody>
</table>

**INQUIRY**

Any questions should be directed to the FGDP Business Office at (310) 794-5750

**AGREEMENT**

1. Each patient's records and materials pertinent to his treatment BECOME THE PROPERTY OF THE FACULTY GROUP DENTAL PRACTICE. The FGDP is authorized to furnish from the patient's record requested information or excerpts to the referring physician, if any; and to any insurance company for the purpose of obtaining payment of the account consistent with applicable HIPAA and California confidentiality laws and regulations.

2. The undersigned agrees, whether he signs as agent or as patient, that in consideration of the services to be rendered to the patient, he hereby individually obligates himself to pay the account to THE REGENTS OF THE UNIVERSITY OF CALIFORNIA in accordance with the regular rates and terms of the Faculty Group Dental Practice of the UCLA School of Dentistry, and to pay professional fees for services rendered. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.

I have read the preceding information and agree to comply with all the rules and regulations for patient processing and treatment.

Patient Signature ___________________________ Date _____________

I consent to whatever dental procedures and anesthetics are necessary for the treatment of

---

**Patient Name (under 21 years of age)** ___________________________ **Signature of Parent / Guardian** ___________________________  

**FGDP (11/2010)**
Dear Patient,

The following is our practice policy regarding the necessity of dental radiographs (x-rays).

Dental radiographs are necessary for accurate diagnosis of many dental conditions. They allow dentists to detect decay and diseases of the mouth, bone, face and jaw that may not be visible during an oral examination. Because dental radiographs help us detect dental conditions early, they play an important role in diagnosis, treatment and prevention of dental problems.

To save you time, money and unnecessary x-rays, we request that you bring your most current dental radiographs that have been taken by your previous dental office to your first appointment with our practice. Your new dentist will review the radiographs to determine if they are adequate, or if new/additional ones are necessary.

If you are unable to bring your current radiographs or forget to do so, a current complete set will be taken by our office in order to complete your examination and the fee will be the patient’s responsibility. Your insurance provider may or may not cover the cost of these radiographs depending upon your plan’s schedule of benefits.

I understand the radiology policy and agree to the conditions.

X____________________________________
PATIENT’S SIGNATURE / DATE