UCSF School of Dentistry
Patient Registration Form

Date_____

1. Name_____ Age_____ Date of Birth_____

2. Street Address _____Social Security#_____

3. City _____ State_____ ZIP_____

Please place an asterisk * next to best phone number to reach you below

4. Home phone (____)_____ Work phone (____)_____

Cell phone (____)_____Other phone (____)_____

Email Address:_____

5. Employer_____ Occupation_____

6. Gender (circle) Male Female Transgender

7. Disability (circle) No Yes & indicate: Partial_____ Total_____
Temporary _____ Permanent _____

8. Do you have Denti-Cal (Welfare)? No___Yes___ B.I.D. #_____

9. Where did you hear about UCSF Dental Clinics: _____

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10. Please select your racial background (you may select more than one):

__ Central American
__ Cuban
__Mexican Amer-Mexican
__Puerto Rican
__South American
__Other Hispanic _____
__African-Amer/Black/Haitian
__American Indian/Native Amer/Alaskan Native
__Caucasian/White/Middle Eastern
__Fijian
__Guamanian
__Hawaiian
__Samoan
__Other Pacific Islander_____

__ Bangladeshi
__ Burmese/Myanmarese
__Chinese
__Filipino
__ Indian
__Indonesian
__Japanese
__Korean
__Laotian
__Malaysian
__Pakistani
__Thai
__Other Asian _____
__Do not wish to respond
__Other

(OVER)

11. In order to IMPROVE our oral health services for you -our patients- please indicate the languages you speak and if you need a clinician who speaks this language.

Languages Spoken: Mark ALL that apply.

___ English	____ Korean	_____ Farsi_____
___ Spanish	____ Vietnamese	_____ Other_____
___ Cantonese	____Tagalog	_____ Other_____
___ Mandarin	____ Russian	_____ Other_____

Do you need an interpreter? (circle) Yes or No

Emergency Contact Information

Name of significant other/closest relative:_____ Relationship: _____
Home Phone( )_____ Cell Phone: ( )_____ Work Phone: ( )_____
In case we cannot reach this contact person; back-up person to contact:
Name: _____ Relationship: _____ Phone: ( ) _____

Financial Responsible Party (If it is the same as the patient, proceed to Insurance information)

First Name:_____ Middle:_____ Last Name:_____ Relationship to Patient:_____
Home Phone: ( )_____ Cell Phone: ( )_____ Work Phone: ( )_____
Street Address: _____ City: _____ Social Security# _____
State: _____ Zip:_____ DOB:_____

Dental Insurance Information

Employer_____ Name of Insurance Company: _____

Mailing Address:_____ Phone Number: ( ) _____

Group#:_____ Policy#:_____

Do you have other DENTAL insurance coverage? (circle) Yes or No

If yes, please fill out the information below for the second coverage.

Policy Holder's Name:_____

Policy Holder's Employer:_____

Policy Holder's Social Security Number:_____

Policy Holder's Gender (circle): Male Female Transgender

Policy Holder's Date of Birth: _____ Policy Holder's Relationship to Patient: _____

Name of Insurance Company:_____

Mailing Address:_____ Phone Number ( ) _____
Group#:_____ Policy #:_____