DENTAL CLINICAL RECORD INTAKE

SIU SOUTHERN ILLINOIS UNIVERSITY CARBONDALE
STUDENT HEALTH SERVICES

Name on SIU Records: ______________________

Preferred Name: ______________ Birth Date: ______________

Student ID: ______________ Today's Date: ______________

Local Address: ______________________

____
City State Zip

How do you want us to contact you if necessary?

☐ Cell phone ☐ Email

☐ Work phone ☐ Other

Gender:

Citizenship ☐ U.S.
☐ International (country of citizenship) ______________

EMERGENCY NOTIFICATION:

Name:

Relationship: ☐ Parent ☐ Guardian ☐ Spouse ☐ Other

Phone

HOW DID YOU HEAR ABOUT STUDENT DENTAL?

☐ Athletic Trainer
☐ ER/Hospital
☐ Dental Hygiene/CDC
☐ Veterans Dept.
☐ Resident Assistant
☐ Instructor/Class
☐ Family/Friend
☐ Medical Clinic/ Wellness
☐ Website (shc.siu.edu)
☐ Facebook/Twitter
☐ Channel 5/Housing
☐ Flyer/Poster/Bulletin
☐ Radio/Television
☐ Newspaper
☐ Other______________

1. Please list any dental concerns:
2. Are you having any dental pain? ☐ Yes ☐ No If yes, where and how long?
3. How often do you visit your dentist? ☐ Twice a year ☐ Once a year ☐ Rarely or Never
4. How often do you brush your teeth each day? ☐ 2-3 times ☐ 1 time ☐ Less than 1 time
5. How often do you floss your teeth? ☐ Everyday ☐ 3-4 times per week ☐ Rarely or Never
6. Do you use fluoride toothpaste?(ie. crest, colgate, aquafresh,etc.) ☐ Yes ☐ No
7. Have you had cavities in the past? ☐ Yes ☐ No
8. How long has it been since your last cavity? ☐ More than 24 months/Never ☐ 12-24 months ☐ Less than 12 months
9. How many times daily do you eat sugary foods between meals? ☐ Only with meals ☐ 1-2 times ☐ 3 or more
10. Do you wear braces, orthodontic appliances, or partial dentures? ☐ Yes ☐ No
11. Does your mouth often feel dry (not enough saliva)? ☐ Yes ☐ No
12. Do you have special care needs limiting your ability to care for your teeth and gums? ☐ Yes ☐ No
13. Do you use chewing gum, mints, or other products that contain (sugar-free) Xylitol? ☐ Yes ☐ No
14. Have you had sealants placed on your teeth? ☐ Yes ☐ No
15. Do you have a history of jaw joint (TMJ) disorder? ☐ Yes ☐ No
16. Do dental treatments cause you much concern, worry, or make you tense? ☐ Yes ☐ No
17. When was your last dental exam? ______________ dental cleaning? ______________ x-rays? ______________
18. Do you need help understanding written or spoken health information? ☐ Yes ☐ No
19. Do you have any special learning or communication needs? ☐ Yes ☐ No If yes, please explain:
20. Do you have any conditions or disabilities that limit your physical activities? ☐ Yes ☐ No If yes, please explain:

Questions #3-14 Cavity Risk Assessment. Copyright 2009 CIGNA. All rights reserved. Reproduced by SIUC with permission of CIGNA.

PATIENT'S MEDICAL HISTORY - PLEASE SELECT YES OR NO

PATIENT'S MEDICAL CONDITION	YES	NO		YES	NO		YES	NO
Heart Failure			Organ Transplant			Hepatitis A, B, C, D, or E		
Heart Disease or Attack			Respiratory Problems			Jaundice or Liver Disease		
Angina Pectoris			Persistent Cough			Kidney Trouble		
High Blood Pressure			Tuberculosis (TB)			HIV/AIDS		
Rheumatic Fever			Asthma			Substance Abuse		
Congenital Heart Lesions			Migraines			Bleeding Disorder		
Heart Murmur			Allergies or Hives			Cold/Canker Sores		
Cancer or Tumor			Sinus Trouble			Epilepsy or Seizures		
Artificial Heart Valve			Diabetes			Eating Disorders		
Heart Surgery or Pacemaker			Thyroid Disease			Fainting or Dizzy Spells		
Appetite Suppressant Drugs			Radiation Treatment			Bruise Easily		
Artificial Joints			Chemotherapy/Cancer Tx			Psychiatric Treatment		
Anemia			Cortisone Medicine			Sickle Cell Disease		
Stroke			Arthritis			Osteoporosis Medication		
Gastrointestinal Issues (ulcers)			Injuries to Jaws or Teeth			Pain in Jaw Joints		
STD's			Sleep Apnea					

Do you have any disease, condition, or problem not listed above? ☐ Yes ☐ No If yes, please list: ____________________

Have you had any serious illness or been hospitalized in the past 5 years? ☐Yes ☐No If yes, why were you hospitalized?

PREGNANCY RISK

Are you pregnant or trying to become pregnant? ☐ Yes ☐ No If pregnant, date expecting ____________________

Are you presently using birth control? ☐ Yes ☐ No If yes, list type ____________________

ADVERSE REACTIONS

CHECK any of the following in which you have had an allergic reaction or sensitivity to:

Local anesthetic	Penicillin	Sulfa Drugs	Tylenol	Demerol	Other:
Latex	Erythromycin	Ibuprofen	Valium	Codeine	
Metals	Other antibiotics	Aspirin	Iodine	Other Narcotics	

MEDICATIONS

Please list all medications (prescription, over-the-counter, supplements, and herbal) you are presently taking & dosages:

SOCIAL

Do you smoke/use tobacco ☐ Yes ☐ No If yes, list the quantity/type in a typical day ____________________

Do you drink alcohol? ☐ Yes ☐ No If yes, list quantity in a typical week ____________________

Do you use recreational drugs? ☐ Yes ☐ No If yes, list type(s) ____________________

1. I acknowledge receipt of the Student Health Center NOTICE OF PRIVACY PRACTICES explaining how my medical information may be used and disclosed, how I can gain access to this information, my rights to inspect, copy, amend, restrict use and disclosure of, receive an accounting of disclosures and my right to file a complaint.
2. I received information about: how I can express my grievances and/or suggestions, information regarding hours and services and patient rights and responsibilities.
3. The information I have provided is accurate to the best of my knowledge.
4. I hereby authorize The Student Dental Service to take x-rays, study models, photographs or any other diagnostic aids to make a thorough dental record and provide dental treatment.
5. I understand there may be cost for some services beyond the $6 door fee and accept responsibility for full payment of these services.

Patient's Signature: ______________________________ **Date:** __________