Tufts University School of Dental Medicine
Research Volunteer Form

Name _____ _____ _____
First *Last* *M.I.*

Home Address _____
Number *Street* *Unit #*

_____
City *State* *Zip Code*

Home Phone (___) _____ - _____ Work Phone (___) _____ - _____

Cell Phone (___) _____ - _____ Email Address _____

Preferred Contact Method ☐Home Phone ☐Work Phone ☐Cell Phone ☐Email

What is your primary race? *(please choose one)*

☐ White, non-Hispanic ☐ Black/African American ☐ Hispanic or Latino
☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander
☐ Multi-Racial ☐ Don't Know ☐ Prefer Not to Answer

What is your primary language?

☐ English	☐ Cambodian	☐ French	☐ Korean	☐ Thai
☐ Chinese	☐ Arabic	☐ Haitian Creole	☐ Portuguese	☐ Vietnamese
☐ Spanish	☐ German	☐ Hindi	☐ Russian	☐ Other: _____

Have you even been a patient at Tufts University School of Dental Medicine? ☐ Yes ☐ No

MEDICAL HISTORY

Date of Birth _____/_____/_____ Gender ☐ Male ☐ Female ☐Other:_____

Caffeine Use ☐ None ☐ Occasional: # of Drinks per Week ____ ☐ Daily: # of Drinks per Day ____

Alcohol Use ☐ None ☐ Occasional: # of Drinks per Week ____ ☐ Daily: # of Drinks per Day ____

Cigarette Use ☐ None ☐ Former: ☐ Current: # Packs per Day _____

Cigar/Pipe Use ☐ None ☐ Former: ☐ Current: # Packs per Day ____

Chew/Smokeless Tobacco ☐ None ☐ Former: ☐ Current: # Packs per Day ____

DENTAL HISTORY

How often do you **visit the dentist**?

☐ Never ☐ 1x Year ☐2x Year ☐ More than 2x a year ☐ Irregular ☐ Emergencies

What **type** of dental care do you receive?

☐ Only when I have problems ☐ At Regular Intervals ☐Inconsistent

How often do you get your teeth **cleaned**?

☐ Never ☐ 1x Year ☐2x Year ☐ More than 2x a year ☐ Irregular ☐ Emergencies

How often do you **brush** your teeth?

☐ Never ☐ 1x Day ☐2x Day ☐ More than 2x a Day ☐ Irregular

What type of tooth brush do you use? ☐ Manual ☐ Electric

How often do you **floss** your teeth?

☐ Never ☐ 1x Day ☐2x Day ☐ More than 2x a Day ☐ Irregular

What dental products do you use?
Toothpaste: _____
Mouth rinse: _____
Other: _____

Do you need antibiotic premedication before dental treatment? ☐ Yes ☐ No
*If yes, please list the condition:*_____

Select all conditions that apply:

☐ Abscess in mouth
☐ Bad Breath
☐ Bad Tastes
☐ Bleeding Gums
☐ Burning Lips
☐ Burning Tongue
☐ Cavities (Tooth Decay)
☐ Cleft Lip/Cleft Palate
☐ Dental Implants
☐ Difficulty Chewing
☐ Dry Eyes
☐ Dry Mouth
☐ Extensive Crowns/ Bridges
☐ Food Traps
☐ Fractured Teeth
☐ Gag Easily
☐ Grinding Teeth
☐ Gum/Bone Surgery
☐ Gum Disease
☐ Gum Recession
☐ Infection in Gums
☐ Jaw Clicking/Popping
☐ Jaw Trauma
☐ Lip Blister
☐ Lip Swelling
☐ Loose Teeth
☐ Lump in Mouth
☐ Misaligned Teeth
☐ Missing Teeth
☐ Mouth Breathing
☐ Mouth Blisters
☐ Mouth Sores
☐ Oral Cancer
☐ Oral Surgery Complications
☐ Orthodontic Treatment
☐ Pain around Ears
☐ Pain in Jaw Joint
☐ Periodontal (Gum) Treatment
☐ Sensitive Gums
☐ Sensitivity to Cold
☐ Sensitivity to Heat
☐ Sensitivity to Pressure
☐ Shifting of Teeth/Change in Bite
☐ Sjögren's Syndrome
☐ Sleep Apnea
☐ Stained Teeth
☐ Tongue Swelling
☐ Tooth Erosion
☐ Toothaches
☐ Worn Fillings
☐ Other _____

By submitting this form, you are authorizing Dental Research Administration (DRA) at TUSDM to store your above disclosed private health information (PHI) so that you can be contacted regarding future dental research studies that may apply to you. This authorization to store your information does not expire, however, you may at any time change your mind and revoke (take back) this authorization. If you decide you do not wish to have your information stored in the future, please contact DRA by email (dentalresearchadministration@tufts.edu), or phone (617-636-4045) and your information will be removed from our database.

All collected data will be stored on a password protected computer, and only DRA personnel will have access to it. Your decision to have or not have your information be retained in our research volunteer database will not affect your receipt of medical care at TUSDM.

I, _____, authorize my PHI to be stored by DRA and be contacted for future clinical research studies.

_____ _____

Signature Date