UNION DENTAL CENTER
Family Dentistry Since 1980

REGISTRATION AND HISTORY

1. PATIENT INFORMATION

Date

SS/HIC/Patient ID #

Patient Name

Last Name

First Name *Middle Initial*

Address

City

State **Zip**

E-mail

Sex ☐ **M** ☐ **F** **Age**

Birthdate

☐ **Married** ☐ **Widowed** ☐ **Single** ☐ **Minor**

☐ **Separated** ☐ **Divorced** ☐ **Partnered for _____ years**

Occupation

Patient Employer/School

Employer/School Address

Employer/School Phone

Spouse Name

Birthdate

SS#

Spouse's Employer

Whom may we thank for referring you?

2. DENTAL INSURANCE

Subscriber/Member #

Relationship to Patient

Insurance Co.

Group #

Is patient covered by additional insurance? ☐ **Yes** ☐ **No**

Subscriber's Name

Birthdate **SS#**

Relationship to Patient

Insurance Co.

Group #

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to

Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____

Signature of Patient, Parent, Guardian or Personal Representative

_____

Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____

Date *Relationship to Patient*

3. PHONE NUMBERS

Home **Work** **Ext.** **Cell Phone**

Spouse's Work **Best time and place to reach you**

EMERGENCY CONTACT (specify someone who does not live in your household)

Name **Relationship**

Home Phone **Work Phone**

UNION DENTAL CENTER
Family Dentistry Since 1980

Patient: _____ **Date of Birth:** _____

4. MEDICAL HISTORY

Physician's Name _____ **Date of last visit** _____

Have you ever taken Fosamax, Actonel, Boniva, Zometa, Aredia or any other biophosphonate? ☐ Yes ☐ No

For Women: Are you Pregnant? ☐ Yes ☐ No **Are you Nursing?** ☐ Yes ☐ No **Are you using any type of birth control?** ☐ Yes ☐ No

Have you had a serious illness or surgery? ☐ Yes ☐ No **If yes, describe** _____

Have you ever had a blood transfusion? ☐ Yes ☐ No **If yes, approximate dates** _____

Are you allergic to or have reacted adversely to any of the following medications: ☐ **Yes** ☐ **No**

(Circle) **Aspirin** **Local Anesthetic** **Erythromycin** **Penicillin** **Codeine** **Latex**

Please circle "Yes" or "No" of the following which you have had or presently have. If none apply, please circle "No"

Anemia	Yes No	**Food Allergies**	Yes No	**Radiation Treatment**	Yes No
Arthritis, Rheumatism	Yes No	**Glaucoma**	Yes No	**Respiratory Disease**	Yes No
Artificial Heart Valves	Yes No	**Headaches**	Yes No	**Rheumatic/Scarlet Fever**	Yes No
Artificial Joints	Yes No	**Heart Murmur**	Yes No	**Rapid weight gain/loss**	Yes No
Asthma	Yes No	**Heart Problems**	Yes No	**Shingles**	Yes No
Back Problems	Yes No	**Hemophilia**	Yes No	**Shortness of Breath**	Yes No
Bleeding Abnormally	Yes No	**Hepatitis**	Yes No	**Skin Rash**	Yes No
Blood Disease	Yes No	**Hernia Repair**	Yes No	**Sleep Apnea**	Yes No
Cancer	Yes No	**High Blood Pressure**	Yes No	**Spinal Bifida**	Yes No
Chemical Dependency	Yes No	**High Cholesterol**	Yes No	**Stroke**	Yes No
Chemotherapy	Yes No	**HIV/AIDS**	Yes No	**Surgical Implant**	Yes No
Circulatory Problems	Yes No	**Jaw Pain**	Yes No	**Swelling of feet or ankles**	Yes No
Cortisone Treatments	Yes No	**Kidney Disease**	Yes No	**Thyroid Problems**	Yes No
Cough, Persistent	Yes No	**Liver Disease**	Yes No	**Tobacco Habit**	Yes No
Cough up Blood	Yes No	**Mitral Valve Prolapse**	Yes No	**Tonsillitis**	Yes No
Diabetes	Yes No	**Nervous Problems**	Yes No	**Tuberculosis**	Yes No
Epilepsy	Yes No	**Pacemaker**	Yes No	**Ulcer**	Yes No
Fainting	Yes No	**Psychiatric Care**	Yes No	**Venereal Disease**	Yes No

List medications you are currently taking and correlating diagnosis

Allergies to any other medications

FOR STAFF USE ONLY I acknowledge all medical information is current and up to date.

PATIENT SIGNATURE	DENTIST SIGNATURE	DATE