United Dental Services

Patient Registration and Health History Form

Please print clearly and fill out form completely

Personal Information

Name: Last _____First_____ MI_____ Nickname_____

Address: Street_____

City_____ State _____ Zip _____

Phone Number: Home# ( )_____, Cell# ( )_____, Work#( )_____

E-mail _____

Social Security # _____ Date of Birth _____

Gender: Male/Female Marital Status: _____

If you have dental insurance

Policy Holder's Name: Last _____ First _____ Date of birth _____

Social Security # _____ Group #_____

Insurance Company Name_____

Employer's Name _____

Health Information

Who is your personal physician? _____ Phone #_____

What are you currently being treated for by your physician?_____

_____

What have you been treated for in the past 5 years? _____

How would you describe your current health? GOOD FAIR POOR

Do you smoke? YES/NO Do you chew tobacco? YES/NO Do you drink alcoholic beverages? YES/NO

List all medications, non-prescription drugs, herbs, and supplements that you are currently taking (include dosage and how frequently you take them) _____

_____

***Have you ever been told by a physician that you must take an antibiotic prior to any type of dental procedure? YES/NO. If yes, why? _____**

Women only:

Are you pregnant? YES/NO If yes, how many weeks _____

Are you nursing? YES/NO

Do you take a contraceptive? YES/NO

GENERAL HEALTH:

Do you have or have been treated for any of the following conditions

Please circle Y (YES) or N (NO). If you answer YES to any questions, please explain and give a date of diagnosis

Y N Abnormal Bleeding/clotting If yes, when?_____

Do you take an anticoagulant? YES/NO INR Score:_____

Y N Alcohol Abuse If yes, when?_____

Y N Allergies If yes, explain_____

Y N Anemia If yes, explain_____

Y N Angina Pectoris/Chest Pain Do you take nitroglycerin? Y/N

Do you have them with you? Y/N

Y N Arthritis If yes, where?_____

Y N Artificial Joints If yes, when? _____

Y N Artificial Heart Valve If yes, when? _____

Y N Asthma If yes, how is it induced?_____

Do you require a rescue inhaler?_____

Y N Cancer-Chemotherapy If yes, when/for how long? _____

Do you have a port currently? YES/NO

Y N Congenital Heart Defect If yes, explain_____

Y N Diabetes Type I(juvenile) Type II Insulin pump YES/NO

Y	N	Difficulty Breathing	If yes, when/how often_____
Y	N	Drug Abuse	If yes, when?_____
Y	N	Emphysema	If yes, when were you diagnosis?_____
Y	N	Epilepsy	If yes, when was your last seizure?_____
Y	N	Fainting spells	If yes, when was the last time?_____
Y	N	Fever Blisters	If yes, how often?_____
Y	N	Heart Attack	If yes, when?_____
Y	N	Heart Murmur	If yes, explain _____
Y	N	Heart Surgery	If yes, explain_____
Y	N	Hemophilia	If yes, what type_____
Y	N	Hepatitis of any type	If yes, please specify type and when_____
Y	N	High Blood Pressure	Do you know your last reading? _____
Y	N	Kidney Problems	If yes, explain _____
Y	N	Liver Disease	If yes, explain_____
Y	N	Low Blood Pressure	Do you know your last reading?_____
Y	N	Mitral Valve Prolapse	Do you have regurgitation? If yes, explain_____
Y	N	Organ transplant?	If yes, when and what organ?_____
Y	N	Pace Maker	If yes, when was it placed?_____
Y	N	Psychiatric Problems	If yes, what is your condition?_____
Y	N	Radiation Therapy	If yes, where on your body and how long?_____
Y	N	Rheumatic Fever	If yes, when?_____
Y	N	Stroke	If yes, when?_____
Y	N	Thyroid Problem	Hypo or Hyper?
Y	N	Tuberculosis	If yes, when?_____

Y N Ulcers? If yes, when and where?_____

Y N Venereal Disease If yes, when?_____

Y N Yellow Jaundice? If yes, when?_____

Are there any other illness that are not listed above that you have had or currently have?_____

_____

List all surgeries/treatments in the last 5 years_____

_____

Have you ever been hospitalized? YES/NO. If yes, please explain _____

_____

Do you have any of the following allergies? If you answer yes to any of the following please explain the symptoms of your reaction and how long ago did it happen.

YES/NO

Y N Aspirin If yes, explain _____

Y N Codeine If yes, explain _____

Y N Dental anesthetics If yes, explain _____

Y N Erythromycin If yes, explain _____

Y N Jewelry If yes, explain _____

Y N Latex If yes, explain _____

Y N Metals If yes, explain _____

Y N Penicillin If yes, explain _____

Y N Tetracycline If yes, explain _____

OTHER?_____

DENTAL HEALTH:

Do you have or have been treated for any of the following conditions

Please circle Y (YES) or N (NO). If you answer YES to any questions, please explain and give a date of treatment

Y N Braces If yes, explain_____

Y N Dental Anxiety If yes, explain_____

Y N Dentures/partials If yes, for how long?_____

Y N Extraction(s) If yes, explain_____

Y N Implants If yes, explain_____

Y N Periodontal treatment If yes, explain_____

Y N Root canal(s) If yes, explain_____

Y N TMJ (grinding/clenching) If yes, explain_____

Y N Do your gums bleed? If yes, explain_____

What is the reason you came here today?_____

_____

By signing below I accept dental treatment for myself and my children, I also understand that I am financially responsible for all fees not covered by my insurance. I authorize UNITED DENTAL SERVICES to submit any insurance claim forms on my behalf and that my signature below shall services as a "Signature on file" until such time as it shall be revoked. I also understand that I am responsible for all legal fees to collect such debts as incurred by myself and my family. I also acknowledge that I have been given the opportunity to review my rights as outlined by the Health Information Privacy Practice.

_____ _____ _____

Signature of Patient/Parent Guardian Print Name Date signed