



**UNIVERSITY OF PITTSBURGH  
UNIVERSITY DENTAL HEALTH SERVICES INC.  
PATIENT REGISTRATION FORM**

Montefiore Hospital      3501 Terrace Street  
3459 Fifth Ave          Suite 3189  
Suite 202 South          Pittsburgh, PA 15261  
Pittsburgh, PA 15213    412-648-9100  
412-648-6730              Fax: 412-383-9829  
Fax: 412-648-6505        Oral Surgery  
Suite G32  
412-648-8604  
Fax: 412-648-3600

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
Referring Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: Last, First, MI _____	Home Phone: _____
Street Address: _____	Business/Cell Phone: _____
City: _____	Gender: M F Marital Status: _____
State: _____ Zip Code: _____	Social Security # (not available online): _____
Employer Name: _____	Date of Birth: _____ E-mail: _____
Employer Address: _____	Employer City: _____
	State: _____ Zip Code: _____

**SUBSCRIBER: DENTAL INSURANCE DATA – Please present your insurance card(s)**

Name: Last, First, MI _____	Home Phone: _____
Street Address: _____	Business/Cell Phone: _____
City: _____	Gender: M F Marital Status: _____
State: _____ Zip Code: _____	Social Security # (not available online): _____
Employer Name: _____	Date of Birth: _____ E-mail: _____
Employer Address: _____	Employer City: _____
	State: _____ Zip Code: _____
<b>Dental Policy #1 – Dental Insurance Company Name:</b> _____	
<b>Dental Policy #1 – Effective Dates:</b> From _____ To: _____	
<b>Dental Policy #1 - Group #:</b> _____ ID#: _____	
Relationship of Patient to Subscriber for <b>Dental Policy #1:</b> _____	
Insurance Verified By: _____	

**SUBSCRIBER: MEDICAL INSURANCE DATA – Please present your insurance card(s)**

Name: Last, First, MI _____	Home Phone: _____
Street Address: _____	Business/Cell Phone: _____
City: _____	Gender: M F Marital Status: _____
State: _____ Zip Code: _____	Social Security # (not available online): _____
Employer Name: _____	Date of Birth: _____ E-mail: _____
Employer Address: _____	Employer City: _____
	State: _____ Zip Code: _____
<b>Medical Policy #1 – Medical Insurance Company Name:</b> _____	
<b>Medical Policy #1 – Effective Dates:</b> From _____ To: _____	
<b>Medical Policy #1 - Group #:</b> _____ ID#: _____	
Relationship of Patient to Subscriber for <b>Medical Policy #1:</b> _____	
Insurance Verified By: _____	

**ACCIDENT INFORMATION – COMPLETE ONLY IF VISIT IS DUE TO AN ACCIDENT**

Date of Accident: \_\_\_\_\_ [Attach Workers' Comp./Auto Insurance Co. Name, Address, and Phone #]  
Type:    Auto          Work-related          Other          Claim #: \_\_\_\_\_

**MINORS: PARENT/GUARDIAN INFORMATION OR EMERGENCY INFORMATION**

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone # Home: \_\_\_\_\_  
Work: \_\_\_\_\_ Cell: \_\_\_\_\_

**RELEASE OF DENTAL/MEDICAL INFORMATION – Please read and sign below**

I request that payment of authorized Medicare/other insurance benefits be made on my behalf to UDHS for any services furnished me by dentist, physician, or supplier. I authorize the release of dental and/or medical information about me to the Centers for Medicine and Medicare and Medicaid Services and/or my insurance company and its agents-any information needed to determine these benefits/benefits payable for related services. I am responsible for all charges, regardless of insurance status, as well as copayments and deductibles.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



UNIVERSITY OF PITTSBURGH  
UNIVERSITY DENTAL HEALTH SERVICES INC.  
**MEDICAL HISTORY**

Montefiore Hospital  
3459 Fifth Ave  
Suite 202 South  
Pittsburgh, PA 15213  
412-648-6730  
Fax: 412-648-6505

3501 Terrace Street  
Suite 3189  
Pittsburgh, PA 15261  
412-648-9100  
Fax: 412-383-9829  
Oral Surgery  
Suite G32  
412-648-8604  
Fax: 412-648-3600

Medical History (please check yes or no)

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Business/Cell Phone: \_\_\_\_\_  
DOB: \_\_\_\_\_ Gender: M F

- Are you under a physician's care now?  Yes  No  
Why? \_\_\_\_\_ Who? \_\_\_\_\_ Phone? \_\_\_\_\_  
Have you ever been hospitalized or had a major operation?  Yes  No  
Discuss \_\_\_\_\_  
Are you taking any medications, pills, or drugs?  Yes  No  
What? \_\_\_\_\_  
Are you on a special diet?  Yes  No  
Discuss \_\_\_\_\_  
Do you use tobacco products?  Yes  No  
How Often? \_\_\_\_\_  
Do you drink alcohol  Yes  No  
How Often? \_\_\_\_\_  
Are you allergic to any medications or substances? \_\_\_\_\_  Yes  No

Please check box below:

- Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex Rubber  
 Other

- Women (please check)  Pregnant/trying to get pregnant  Nursing  
 Taking oral contraceptives

Do you now have or have you ever had any of the following (please check appropriate boxes).

	Yes/No		Yes/No		Yes/No
Heart Trouble/Disease	<input type="checkbox"/> <input type="checkbox"/>	Bloody Sputum	<input type="checkbox"/> <input type="checkbox"/>	Stroke	<input type="checkbox"/> <input type="checkbox"/>
Heart Murmur	<input type="checkbox"/> <input type="checkbox"/>	Fainting or Dizziness	<input type="checkbox"/> <input type="checkbox"/>	Glaucoma	<input type="checkbox"/> <input type="checkbox"/>
Angina/Chest Pain	<input type="checkbox"/> <input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/> <input type="checkbox"/>	Emphysema	<input type="checkbox"/> <input type="checkbox"/>
Heart Attack	<input type="checkbox"/> <input type="checkbox"/>	Need Medication before Dental Appt.	<input type="checkbox"/> <input type="checkbox"/>	Tuberculosis	<input type="checkbox"/> <input type="checkbox"/>
Congenital Heart Disorder	<input type="checkbox"/> <input type="checkbox"/>	Bruise or Bleed Easily	<input type="checkbox"/> <input type="checkbox"/>	X-Ray Treatment(Radiation)	<input type="checkbox"/> <input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/> <input type="checkbox"/>	Anemia	<input type="checkbox"/> <input type="checkbox"/>	Chemotherapy	<input type="checkbox"/> <input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/> <input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/> <input type="checkbox"/>	Stomach/Intestinal Disease	<input type="checkbox"/> <input type="checkbox"/>
<b>Artificial Heart Valve</b>	<input type="checkbox"/> <input type="checkbox"/>	Hemophilia (Bleeding Problems)	<input type="checkbox"/> <input type="checkbox"/>	Recent Weight Loss/Gain	<input type="checkbox"/> <input type="checkbox"/>
Heart Pace Maker	<input type="checkbox"/> <input type="checkbox"/>	Leukemia	<input type="checkbox"/> <input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/> <input type="checkbox"/>
Coronary Stent	<input type="checkbox"/> <input type="checkbox"/>	Mouth Ulcers	<input type="checkbox"/> <input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/> <input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/>	Recent Blood Transfusion	<input type="checkbox"/> <input type="checkbox"/>	Diabetes	<input type="checkbox"/> <input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/> <input type="checkbox"/>	Lung Disease	<input type="checkbox"/> <input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/> <input type="checkbox"/>
Blood Disease	<input type="checkbox"/> <input type="checkbox"/>	Swelling of Limbs	<input type="checkbox"/> <input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/> <input type="checkbox"/>
Alcoholism	<input type="checkbox"/> <input type="checkbox"/>	Breathing Problem	<input type="checkbox"/> <input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/> <input type="checkbox"/>
Liver Disease	<input type="checkbox"/> <input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/> <input type="checkbox"/>	Drug Addiction	<input type="checkbox"/> <input type="checkbox"/>
Yellow Jaundice	<input type="checkbox"/> <input type="checkbox"/>	Frequent Cough	<input type="checkbox"/> <input type="checkbox"/>	Tumors or Growths	<input type="checkbox"/> <input type="checkbox"/>
Cold Sores	<input type="checkbox"/> <input type="checkbox"/>	Asthma	<input type="checkbox"/> <input type="checkbox"/>	Allergies (pollen/dust)	<input type="checkbox"/> <input type="checkbox"/>
HIV+/AIDs	<input type="checkbox"/> <input type="checkbox"/>	Immuno Compromised	<input type="checkbox"/> <input type="checkbox"/>	Fever Blisters/Herpes	<input type="checkbox"/> <input type="checkbox"/>
CD4 count _____		Venereal Disease	<input type="checkbox"/> <input type="checkbox"/>	Genital Herpes	<input type="checkbox"/> <input type="checkbox"/>
Hives or Rash	<input type="checkbox"/> <input type="checkbox"/>	Kidney Problems	<input type="checkbox"/> <input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/> <input type="checkbox"/>
Parathyroid Disease	<input type="checkbox"/> <input type="checkbox"/>	Arthritis/Gout	<input type="checkbox"/> <input type="checkbox"/>	Pain in Jaw Joints	<input type="checkbox"/> <input type="checkbox"/>
Cortisone/Steroids	<input type="checkbox"/> <input type="checkbox"/>	<b>Artificial Joint</b>	<input type="checkbox"/> <input type="checkbox"/>	Epilepsy	<input type="checkbox"/> <input type="checkbox"/>
Hepatitis A (Infectious)	<input type="checkbox"/> <input type="checkbox"/>	Hepatitis B or C	<input type="checkbox"/> <input type="checkbox"/>	Convulsions/Seizures	<input type="checkbox"/> <input type="checkbox"/>
Nervousness	<input type="checkbox"/> <input type="checkbox"/>				



UNIVERSITY OF PITTSBURGH  
 UNIVERSITY DENTAL HEALTH SERVICES INC.  
**MEDICAL HISTORY**(continued)

Montefiore Hospital  
 3459 Fifth Ave  
 Suite 202 South  
 Pittsburgh, PA 15213  
 412-648-6730  
 Fax: 412-648-6505

3501 Terrace Street  
 Suite 3189  
 Pittsburgh, PA 15261  
 412-648-9100  
 Fax: 412-383-9829  
 Oral Surgery  
 Suite G32  
 412-648-8604  
 Fax: 412-648-3600

Medical History (continued)

Patient Name: \_\_\_\_\_

Have you ever had any other serious illness not checked above?      Yes      No

Discuss \_\_\_\_\_

Do you wish to talk to the dentist privately about any problems?      Yes      No

\_\_\_\_\_

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medications change, I shall inform the dentist and staff at the next appointment without fail.

**X** \_\_\_\_\_ Date: \_\_\_\_\_  
 Patient Signature (Parent or Guardian)

Reviewed by Doctor \_\_\_\_\_ Date \_\_\_\_\_ BP \_\_\_\_\_

History Review and Significant Findings \_\_\_\_\_

Medical Updates

I have read my MEDICAL HISTORY dated \_\_\_\_\_ and confirm that it adequately states past and present conditions.

Date	Exceptions	None	Patient's Signature	BP	Reviewed By
_____	_____		_____	_____	_____
_____	_____		_____	_____	_____
_____	_____		_____	_____	_____
_____	_____		_____	_____	_____
_____	_____		_____	_____	_____
_____	_____		_____	_____	_____
_____	_____		_____	_____	_____

\* Please print a copy and bring it to the office at your next appointment.