



**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: _____
Dental Policy #1 – Dental Insurance Company Name: _____	
Dental Policy #1 – Effective Dates: From _____ To: _____	
Dental Policy #1 - Group #: _____ ID#: _____	
Relationship of Patient to Subscriber for Dental Policy #1: _____	
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: _____
Medical Policy #1 – Medical Insurance Company Name: _____	
Medical Policy #1 – Effective Dates: From _____ To: _____	
Medical Policy #1 - Group #: _____ ID#: _____	
Relationship of Patient to Subscriber for Medical Policy #1: _____	
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: _____



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DENTAL HISTORY

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Patient Name: _____

Primary reason for this dental appointment:

Examination Emergency Consultation

Dental History (please check yes or no)

Do you have a specific dental problem? Yes No

Describe: _____

Do you have dental examinations on a routine basis? Yes No

Date of Last Visit: _____

Do you think you have active decay or gum disease? Yes No

Discuss: _____

Do you brush and floss on a routine basis? Yes No

Discuss: _____

Do your gums ever bleed? Yes No

Discuss: _____

Do you like your smile? Yes No

Why? _____

Does food catch between your teeth? Yes No

Any loose teeth? _____

Do you want to keep your remaining teeth? Yes No

Discuss: _____

Do you ever have clicking, popping or discomfort in the jaw joint? Yes No

Discuss: _____

Do you brux or grind? Yes No

Discuss: _____

Have your past experiences in a dental office always been positive? Yes No

Discuss: _____

Do you smoke or chew? Any sores in mouth? Yes No

Discuss: _____

Name of previous dentist (optional)

Date of last full mouth x-rays (16 small films or panoramic):

Date of last bitewing x-rays (looks for cavities between teeth):

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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"/>
Artificial Heart Valve	<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"/>	Artificial Joint	<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"/>				



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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.