UNION FAMILY DENTAL CLINIC

PATIENT NAME: **SEX:** **DATE OF BIRTH:** **S.S.#** **INSURANCE ID#**

PREFFERED NAME: **PHONE NOS: (HOME):** **(CELL):** **(WORK):**

ADDRESS: **APT/UNIT NO:** **CITY:** **STATE:** **ZIPCODE:**

PARENT/SPOUSE'S NAME: **DOB:** **E-MAIL ADDRESS:**

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED, BESIDES PERSON LISTED ABOVE? **PHONE NUMBER:**

WHOM MAY WE THANK FOR REFERRING YOU?

FEMALES: ARE YOU PREGNANT OR TRYING TO GET PREGNANT? **IF SO, DUE DATE:** **ARE YOU NURSING?**

NAME OF OB/GYN DR: **PHONE NO:** **ARE YOU TAKING ORAL CONTRACEPTIVES?**

LIST ANY MEDICATIONS, NOTING REASON, DOSEAGE& FREQUENCY (USE SEPARATE PAGE IF TOO MANY TO LIST);

HAVE YOU HAD MAJOR SURGERY OR BEEN HOSPITALIZED IN PAST FIVE YEARS? **Reason/ Date:**

HAVE YOU EVER HAD A SERIOUS HEAD OR NECK INJURY?

ARE YOU UNDER A PHYSICIAN'S CARE NOW: **IF SO, PLEASE EXPLAIN:**

PHYSICIAN'S NAME/PHONE NUMBER: **DATE OF LAST PHYSICAL EXAM:**

Are you allergic to any of the following? ASPIRIN: **PENICILLIN:** **CODEINE:** **LATEX:**

SULFA DRUGS: **LOCAL ANESTHESIA:** **ACRYLIC:** **FOOD/OTHER ALLERGY: <explain>**

Does patient have, or has ever had, any of the following? **Does patient use tobacco products? □Yes □No**

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS/HIV POSITIVE	□	□	CORISONE MEDICINE	□	□	HEMOPHELIA	□	□	RADIATION TREATMENTS	□	□
ALZHEIMER'S	□	□	DIABETES	□	□	HEPATITIS A	□	□	RECENT WEIGHT LOSS	□	□
ANAPHYLAX	□	□	DRUG ADDICTION	□	□	HEPATITIS B or C	□	□	RENAL DIALYSIS	□	□
ANEMIA	□	□	EASILY WINDED	□	□	HERPES	□	□	RHEUMATIC FEVER	□	□
ANGINA	□	□	EMPHYSEMA	□	□	HIGH BLOOD PRESSURE	□	□	RHEUMATISM	□	□
ARTHRITIS/GOUT	□	□	EPILEPSY OR SEIZURES	□	□	HIGH CHOLESTEROL	□	□	SCARLET FEVER	□	□
ART.HEART VALVE	□	□	EXCESSIVE BLEEDING	□	□	HIVES OR RASH	□	□	SHINGLES	□	□
ARTIFICIAL JOINT	□	□	EXCESSIVE THIRST	□	□	HYPOGLYCEMIA	□	□	SICKLE CELL DISEASE	□	□
ASTHMA	□	□	FAINTING /DIZZINESS	□	□	IRREGULAR HEARTBEAT	□	□	SINUS TROUBLE	□	□
BLOOD DISEASE	□	□	FREQUENT COUGH	□	□	KIDNEY PROBLEMS	□	□	SPINA BIFADA	□	□
BLOOD TRANS	□	□	FREQUENT DIARRHEA	□	□	LEUKEMIA	□	□	STOMACH/INTEST DISEASE	□	□
BREATHING PROBLEMS	□	□	FREQUENT HEADACHE	□	□	LIVER DISEASE	□	□	STROKE	□	□
BRUISE EASILY	□	□	GENITAL HERPES	□	□	LOW BLOOD PRESSURE	□	□	SWELLING OF LIMBS	□	□
CANCER	□	□	GLAUCOMA	□	□	LUNG DISEASE	□	□	THYROID DISEASE	□	□
CHEMOTHERAPY	□	□	HAY FEVER	□	□	MITRAL VALVE PROL	□	□	TONSILLITIS	□	□
CHEST PAINS	□	□	HEART ATTACK/FAILURE	□	□	OSTEOPOROSIS	□	□	TUBERCULOSIS	□	□
Cold Sore/Fever Blisters	□	□	HEART MURMUR	□	□	PAIN IN JAW JOINTS	□	□	TUMORS OR GROWTHS	□	□
CONG.HEART DISORDER	□	□	HEART PACEMAKER	□	□	PARATHYROID DISEASE	□	□	ULCERS	□	□
CONVULSIONS	□	□	HEART TROUBLE/DISEASE	□	□	PSYCHIATRIC CARE	□	□	VENEREAL DISEASE	□	□
									YELLOW JAUNDICE	□	□

Has patient ever had or has any serious illness or conditions not listed above? □Yes □No If "yes", please list:

ADDITIONAL INFORMATION/COMMENTS:

TO THE BEST OF MY KNOWLEDGE, THE QUESTIONS ON THIS FORM HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY (OR THE PATIENT'S) HEALTH: IT IS MY RESPONSIBLITY TO INFORM THE DENTAL OFFICE OF ANY CHANGES IN MEDICAL STATUS.

SIGNATURE OF PATIENT,PARENT OR GUARDIAN: **DATE:**

UNION FAMILY DENTAL CLINIC

Dental Treatment Release Form

I give permission for Union Family Dental Clinic to release any Dental Treatment completed or to be complete to persons names listed below.

_____ _____ _____

Signature Print Name Date

Name: _____

Phone Number: _____

Relationship to You: _____

Name: _____

Phone Number: _____

Relationship to You: _____

Name: _____

Phone Number:_____

Relationship to you _____

UNION FAMILY DENTAL CLINIC

PATIENT APPOINTMENT POLICIES

We at **UNION FAMILY DENTAL CLINIC (UFDC)** believe that the best relationships are based on mutual respect. We believe both your time and our time is valuable and should be respected. We strive to keep our schedule organized and on time in order to minimize wait time, while maximizing your time here. We therefore ask that you read and agree to the below patient polices.

CANCELLATIONS: UFDC **requires 24 hour notice of any cancellations**. Cancellations without 24 hours of appointment may be considered a failure. We are aware and understand that emergencies due arise and we will review on a "case by case" basis.

FAILURES: Listed below is the failure policy

FIRST & SECOND FAILED APPTS (within twelve month period)

Appointments will be rescheduled

THIRD FAILED APPT (within twelve month period)

Appointment will be rescheduled, but you will be seen on a **"STANDBY BASIS ONLY"**. You can still be seen at UFDC, but you will **not be given a guaranteed slot**. After three "STANDBY" APPOINTMENTS, you will be able to schedule a guaranteed appointment time for future appointments.

APPOINTMENT TIMES: **UFDC**

We grant a ten minute grace period to arrive at your appointment. AFTER TEN MINUTES, your appointment may be rescheduled, based on the schedule time available, and the reason for the delay. We at UFDC strive very hard to stay on schedule, so as not to waste your time, and we appreciate the same for our time.

APPOINTMENT CONFIRMATION:

Union Family Dental Clinic office policy requires you to confirm your appointment by 2pm the day before scheduled appointment. **The office will make two (2) attempts within 48 hour time span to reach you. Unfortunately, if we do not receive a response OR if unable to reach you, we will be required to move the appointment to standby status.**

Please feel free to leave a message if the office is closed or phones are busy, 704-776-4157.

We therefore ask that since you read this and agree to the above patient policies. Your signature merely represents a good faith agreement between our patients and UFDC.

Date:_____

Signature:_____ Name of Patient(s):_____

Revised May 2013