



UNION DENTAL GROUP

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as possible. If you have questions, we will be glad to help you. We look forward to work with you in maintaining your dental health.

PATIENT INFORMATION

First name		Last Name		Middle Initial				
Address								
Street		City		State	Zip			
Home Phone		Cell Phone						
Sex:	<input type="radio"/> Male	<input type="radio"/> Female	Marital Status:	<input type="radio"/> Single	<input type="radio"/> Married	<input type="radio"/> Divorced	<input type="radio"/> Separated	<input type="radio"/> Widowed
Date of Birth		Age		Social Security #			Driver License #	
Email								

RESPONSIBLE PARTY (If different than the patient)

First name		Last Name		Middle Initial	
Address					
Street		City		State	Zip
Home Phone		Cell Phone			
Date of Birth		Social Security #		Driver License #	

MEDICAL HISTORY

Physician Name		Telephone #		Fax #	
Have you had any serious illnesses or operations? <input type="radio"/> Yes <input type="radio"/> No If yes, describe					
Do you take, or have you taken, Phen-Fen or Redux? <input type="radio"/> Yes <input type="radio"/> No					

WOMEN

Pregnant / Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

* Mark all that applies to you:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> AIDS/HIV + | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hepatitis () | <input type="checkbox"/> Radiation Treatments |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Renal Dialysis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Fainting | <input type="checkbox"/> Jaw pain / TMJ | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Cancer () | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Ulcers |

MEDICATIONS

List all medications you are currently taking:

ALLERGIES

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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ DATE _____

◆◆ INSURANCE INFORMATION ◆◆

PRIMARY INSURANCE

Subscriber Name _____ Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other
Subscriber SSN / Member ID _____ Group # _____ Date of Birth _____
Address (if different from patient's) _____
Street City State Zip
Employer _____
Business Address _____
Street City State Zip
Insurance Company _____ Phone Number _____
Address _____
Street City State Zip
Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Subscriber Name _____ Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other
Subscriber SSN / Member ID _____ Group # _____ Date of Birth _____
Address (if different from patient's) _____
Street City State Zip
Employer _____
Business Address _____
Insurance Company _____ Phone Number _____
Address _____
Street City State Zip
Names of other dependents covered under this plan _____

SIGNATURE ON FILE

I certify that I, and/or my dependent(s), have insurance coverage with listed insurance company above and assign directly to all doctors in Union Dental Group 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. Union Dental Group may use my health care information and may disclose such information to the above-named insurance company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This content will end when my current treatment plan is completed or one year from the date signed below.

Subscriber Name _____ Relationship to the patient _____
Subscriber Signature _____ Date _____