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: ○ Male ○ Female Marital Status: ○ Single ○ Married ○ Divorced ○ Separated ○ Widowed

Date of Birth _____ Age _____ Social Security # N/A Driver License # N/A

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? ○ Yes ○ No If yes, describe _____

Do you take, or have you taken, Phen-Fen or Redux? ○ Yes ○ No _____

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

* Mark all that applies to you:

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

PAYMENT IS DUE AT THE TIME OF SERVICE

The Union Dental Group is committed to provide you the best possible care. Our team always strives to optimize your use of dental benefits to minimize your out of pocket cost. In order to provide our patient with the best financial arrangements, it is important for you to understand our financial policy first.

PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS PAYMENT ARRANGEMENTS HAVE BEEN MADE AND APPROVED IN ADVANCE. We accept cash, VISA, MasterCard, American Express, cashier's checks, and Care Credit. We do NOT accept any personal or business checks. All payments or deposits made are NOT refundable.

As an insured patient, you must realize that:

1. The insurance is a contract between the patient, the employer, and the insurance company. Union Dental Group is NOT a part of the contract.
2. The majority of the services are not covered by the insurance company at 100%, and specific treatments might not be covered at all depending on the coverage the patient has.
3. Any applicable deductibles and co-pay percentages as per plan description must be paid at the time of service.
4. The patient is obligated to inform our office regarding any changes made to the dental insurance policy, so that we may process the claims in a timely manner.
5. IF THE INSURANCE COMPANY DENIES MAKING PAYMENTS FOR ALREADY RENDERED SERVICES FOR ANY REASON, the patient and/or the guardian agrees to accept financial responsibility for the payment of all unpaid portions.

We must emphasize that as healthcare providers, our relationship is with you, the patient, not your insurance company. Often we do not receive the insurance payments until two to three months after being submitted; therefore, we do ask that you pay your estimated share at the time treatment is rendered. In case of financial difficulties that may affect your contracted payment schedules, please contact our financial advisor for assistance so that we may be able to rearrange the financial options for you.

If you have any questions about the above information, please do not hesitate to ask us. We are here to serve you.

I HAVE READ THE POLICIES DESCRIBED IN THIS FORM. I AGREE TO ABIDE BY THE TERMS OUTLINED. I UNDERSTAND AND ACCEPT MY FINANCIAL RESPONSIBILIES AND WILL PAY ANY BALANCE DUE BY THE DUE DATE.

Patient's Name _____

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Patient's Signature _____ Date _____