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 # _____ 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? ○ 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 _____

Informed Consent
General Dentistry

Chart # _____

1. EXAMINATIONS AND X-RAYS

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. I understand I am to have work done as detailed in the attached treatment plan.

2. DRUGS, MEDICATION AND SEDATION

I have been informed and understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I have informed the Dentist of any known allergies. They may cause drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic, medication and drugs that may have been given me in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills).

3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

4. PERIODONTAL TREATMENT

I understand that I have a serious condition causing gum inflammation and/or bone loss, and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including non-surgical cleaning, gum surgery, and/or extractions. I understand the success of any treatment depends in part on my efforts to brush and floss daily, receive regular cleanings as directed, follow a healthy diet, avoid tobacco products and follow other recommendations. I understand that periodontal disease may have a future adverse effect on the long-term success of dental restorative work.

5. TEMPOROMANDIBULAR JOIN DYSFUNCION (TMD)

I understand that popping, clicking, locking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility.

6. FILLINGS

I understand that a more extensive restoration than originally diagnosed may be required due to additional decay or unsupported tooth structure found during preparation. This may lead to other measures necessary to restore the tooth to normal function. This may include root canal, crown, or both. I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage. I understand that sensitivity is a common after effect of a newly placed filling.

7. REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy, crown, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth _____and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, exposed sinuses, loss of feeling in my teeth, lips, tongue and surrounding tissue (Parasthesia) that can last for an indefinite period of time or fractured jaw. I understand that I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

8. BLEACHING

Bleaching is a procedure done either in office (approximately 1 hour) or with take-home trays (several treatments over 2-4 weeks). The degree of whitening varies with the individual. The average patient achieves considerable change (1-3 shades on the dental shade guide). Coffee, tea and tobacco will stain teeth after treatment and are to be avoided for at least 24 hours after treatment. I understand I may experience sensitivity of the teeth and/or gum inflammation, which will subside when treatment is discontinued. The Dentist may prescribe fluoride treatments for rare cases of persistent sensitivity. Carbamide peroxide and other peroxide solutions used in teeth bleaching are approved by the FDA as mouth antiseptics. Their use as bleaching agents has unknown risks. Acceptance of treatment means acceptance of risk. Pregnant women are advised to consult with their physician before starting treatment.

9. CROWNS, BRIDGES, VENEERS AND BONDING

a. I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize that the final opportunity to make changes in my new crown, bridge, or veneer (including shape, fit, size and color) will be before cementation. It has been explained to me that, in a very few cases, cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures. It is also my responsibility to return for permanent cementation with in 20days after tooth preparation. Excessive delays may allow for decay, tooth movement, gum charges, and/or bite problems. This may necessitate a remake of the crown, bridge, or veneer. I understand there will be additional charges for remakes or other treatment due to my delaying permanent cementation.

b. I am electing to follow the Dentist's recommendation of using high noble instead of base metal in my crown and bridge restorations.

c. I am electing to do a fixed bridge or implant replacement of missing teeth instead of a removable appliance. I understand that this fixed bridge or implant and crown may not be a covered benefit under my insurance policy.

10. DENTURES – COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. Immediate dentures (placement of dentures immediately after extractions) may be uncomfortable at first. Immediate dentures may require several adjustments and relines. A permanent reline or a second set of dentures will be necessary later. This is not included in the initial denture fee. I understand that it is my responsibility to return for delivery of dentures. I understand that failure to keep delivery appointments may result in poorly fitted dentures. If a remake is required due to my delay of more than 30 days, there will be additional charges.

11. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, that complications can occur from the treatment, and that occasionally, canal material may extend through the root tip which does not necessarily affect the success of the treatment. The tooth may be sensitive during treatment and even remain tender for a time after treatment. Hard to detect root fracture is one of the main reasons root canals fail. Since teeth with root canals are more brittle than other teeth, a crown is necessary to strengthen and preserve the tooth. I understand that endodontic files and reamers are very fine instruments and stresses can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (Apicoectomy). I understand that the tooth may be lost in spite of all efforts to save it.

12. DENTAL BENEFITS

I understand that my insurance may provide only the minimum standard of care. I understand that submitting insurance and receiving a benefit is my responsibility. I elect to follow the Dentist's recommendation of optimal dental treatment.

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist or corporate entity, other that the treating Dentist, is responsible for my dental treatment. I acknowledge the receipt of and understand post-operative instructions and have been given an appointment date to return.

Patient's/Guardian's Name _____ Relationship to Patient _____

Patient's/Guardian's Signature _____ Date _____

Doctor's 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 _____

Patient's Signature _____ Date _____