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