UNITED DENTAL GROUP

Welcome to our Office: PLEASE COMPLETE THE FOLLOWING FORM IN ORDER TO AID IN EVALUATING YOUR DENTAL HEALTH. (PLEASE PRINT CLEARLY)

Date:______________________

◯ Mr. ◯Mrs. ◯Ms. ◯Child____Date of Birth______________

FIRST NAME MIDDLE INITIAL LAST NAME MM/DD/YYYY

Home Address____-____________

STREET NAME AND NUMBER APT/SUITE CITY STATE ZIPCODE

Phone number (H): ______________ (C):_______________(W):______________Occupation______________

E-Mail Address:____Employer________________________

Spouse name:_________________________ Spouse Contact Information:______________________________

Parent/Guardian Info (to be filled if patient under 18 yrs. Old):

Name____DOB:_____________Ph. No.________________

INSURANCE INFORMATION: Do You Have Dental Insurance? ◯Yes ◯No

Subscriber's Full name ___________________________________Subscriber's Date of Birth_______________

FIRST NAME MIDDLE INITIAL LAST NAME MM/DD/YYYY

Insurance Carrier______________________Group #__________________ID/Social Security_______________

Secondary insurance(if any)_______________________________ID:_________________________________

MEDICAL AND DENTAL HISTORY:

Have you ever had an unfavorable reaction following dental treatment? ◯Yes ◯No
If yes, please discuss with the doctor.
Have you ever had excessive bleeding requiring special treatment? ◯Yes ◯No
Female patients, is there any chance you may be pregnant or nursing? ◯Yes ◯No

LIST OF ALLERGIES______________________
____
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Check off any of the following you may have or had:

◯HEART TROUBLE/ANGINA	◯HIGH BLOOD PRESSURE	◯STOMACH ULCER
◯HEART MURMUR	◯ANEMIA	◯KIDNEY DISEASE
◯ASTHMA	◯RHEUMATIC FEVER	◯FAINTING SPELLS
◯DIABETES	◯LUPUS	◯SINUS INFECTIONS
◯ARTHRITIS	◯NERVOUS DISORDERS	◯NECK INJURY
◯JAUNDICE	◯CORTISONE TREATMENT	◯CANCER TREATMENT
◯STROKE	◯PSYCHIATRIC TREATMENT	◯SICKLE CELL DISEASE
◯EPILEPSY	◯MIGRAINE/HEADACHES	◯LIVER DISEASE
◯GLAUCOMA	◯HERPES	◯THYROID DISORDER
◯HEPATITIS A/B	◯MITRAL VALVE PROLAPSE	◯ADDICTIONS
◯VENEREAL DISEASE	◯ARTIFICIAL VALVE/PROSTHESES	◯TMJ PROBLEMS
◯CONGENITAL HEART DISORDER	◯BLOOD TRANSFUSION	◯HIV+/AIDS
◯CARDIAC PACEMAKER	◯TUBERCULOSIS (TB)	

Others (please specify)_______________________________
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DENTAL HISTORY

Are you presently in pain? ◯Yes ◯No
Is any part of your mouth sensitive to the following?
◯HOT ◯COLD ◯BITING ◯SWEETS

◯OTHERS______________________________
Reason for visit/ chief complaint:__________
____
____
Last dental visit_______________________
Referred by:__________________________

IN THE EVENT THAT THE INSURANCE COMPANY DOES NOT HONOR A CLAIM, OR IF AN ERROR IN ASSIGNMENT OF BENEFITS IS MADE, I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR PAYMENT OF THE SERVICES RENDERED

PATIENT/GUARDIAN SIGNATURE__________________________ **DOCTOR'S SIGNATURE**________________________
DATE____ **DATE**______________________________________