Unison Dental/Urgent Dental Care

Patient Information

Patient's Legal Name _____

Preferred First Name _____

Address _____ City _____ State __ Zip _____

Phone – Primary _____ Secondary _____ Work _____

Social Security #_____ Email Address _____

Birth Date _____ Age ___ Sex: M☐ F☐ Marital Status: Single☐ Married☐ Child☐

Full Time Student☐ Where? _____

How did you find out about our practice? _____

Responsible Party Information

Only fill out if responsible party is different from above.

Full Name _____

Address _____ City _____ State __ Zip _____

Phone – Primary _____ Secondary _____ Work _____

Relationship to patient _____

Dental Insurance Information

If you have dental insurance please have your card copied. If the red text is not filled out, we cannot file your insurance for you.

Employee Name _____ SS # _____ Birth Date _____

Employer _____ Phone _____

Insurance Co. _____ Group # _____ Employee ID # _____

Ins. Claims Address _____ Phone _____

Do you have dual coverage? ☐ Please complete this secondary insurance information.

Employee Name _____ SS # _____ Birth Date _____

Employer _____ Phone _____

Insurance Co. _____ Group # _____ Employee ID # _____

Ins. Claims Address _____ Phone _____

(For Office Use Only)

Effective Date_____ **Name of INS Rep** _____

Annual Maximum Benefit $_____ **Used**_____ **Deductible: Have they been met? Yes No**

_____**%Preventive** **$**_____ **Preventive**

_____**%Basic** **$**_____ **Standard**

_____**%Major Oral Surgery Perio Endodontics** **$**_____ **Other**
(Circle above if part of major)

Missing Tooth Clause YES NO **Any other important info:**_____

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Medical Information

Yes No

☐ ☐ Are you having pain or discomfort at this time? Please describe _____

☐ ☐ Are you in good health? Date of last Medical Examination _____

Physician's Name _____ Address or Phone _____

☐ ☐ Have you been under the care of a medical doctor during the last two years? For what? _____

_____

☐ ☐ Are you taking any medication now? For what? _____

_____

☐ ☐ Are you allergic to any medication, latex, or anesthetics? If yes, please list. _____

_____

☐ ☐ Do you smoke? How long? _____ How much? _____ Do you chew tobacco? _____

☐ ☐ Have you been advised to be pre-medicated with antibiotics before dental treatment?

If yes, why? _____

Please check the ☐ if you have or have had any of the following conditions:

☐ Heart Disease, Attack, or problem
☐ Heart Murmur
☐ Rheumatic Fever
☐ Mitral Valve Prolapse
☐ Artificial Heart Valve
☐ Heart Surgery
☐ Artificial joints (hip, knee)
☐ High Blood Pressure
☐ Stroke
☐ Diabetes
☐ Kidney Disease
☐ Cancer or Tumor
☐ Radiation Therapy
☐ Bleeding problems
☐ Respiratory problems
☐ Emphysema or Chronic Cough
☐ Asthma
☐ Sinus Trouble
☐ Hepatitis A (Infectious)
☐ Hepatitis B (Serum)
☐ Hepatitis C
☐ Liver Disease
☐ HIV Positive
☐ AIDS
☐ Sexually Transmitted Disease
☐ Cold Sores, Fever Blisters
☐ Herpes
☐ History of Drug Abuse
☐ Psychiatric Care
☐ ADD/ADHD
☐ Epilepsy or Seizures
☐ Fainting Spells
☐ Nervousness Disorders
☐ Stomach Ulcer
☐ Allergy to Latex
☐ _____

Women Only

☐ Are you Pregnant? What is your due date? _____
☐ Taking oral contraceptives

Consent:

1. I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.
2. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
3. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deem ed fit to provide recommended treatment.
4. I acknowledge I have reviewed the office's HIPPA Privacy policy, and may receive a copy at my request.
5. I understand that all responsibility for payment for dental services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered unless other arrangements have been made.
6. Should your account be turned over for collection, the undersigned agrees to pay all costs to collect the debt, including, but not limited to, interest in the amount of 18% per annum, attorney's fees, court costs, and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third party debt collection agency.

Patient Signature _____ Date _____

(Parent or Guardian if patient is a minor)