UNIVERSITY Dental Group P.L.
Cosmetic • Restorative • Preventive

Patient Form

Patient Personal Information

Patient's Full Name *

Nickname

Birth Date *

Gender *

Marital Status

Street Address *

City *

State *

Zip Code *

Email *

Cell Phone *

Work Phone

Home Phone

How do you prefer to be contacted?

☐ Text ☐ Home Phone ☐ Cell Phone
☐ Email ☐ Work Phone

Dental Insurance Information

Name of Subscriber

Primary Dental Insurance Company

Dental Insurance ID Group #

Dental Insurance Phone Number

Subscriber's Social Sec. #

Relationship of Patient to Subscriber

Subscriber's Date of Birth

Subscriber's Employer

Medical Insurance Information

(used if a medical diagnosis is made)

Name of Subscriber

Subscriber's Date of Birth

Relationship of Patient to Subscriber

Medical Insurance Company

Medical Insurance Group #

Medical Insurance ID #

Do you have any additional dental or medical insurance?

How did you hear about us?

☐ Another Patient (Please indicate who) [ ]

☐ Staff Member	☐ Local Physician	☐ Yellow Pages
☐ Website	☐ ZocDoc.com	☐ Location/Sign
☐ Search Engine	☐ YP.com	☐ Other
☐ BookThatDoc.com		

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for University Dental Group, P.L. A copy of this signed, dated Acknowledgment shall be as effective as the original.

☐ **I have read and I understand the HIPPA disclosure agreement that the University Dental Group provided me.**

Patient's Full Name * **Sign Name (Re-type Name)** *

Consent for treatment and financial policies:

Please initial each box, and sign at the bottom

☐ I authorize the doctor to make X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of me or my dependent's dental needs.

☐ I authorize the doctor to perform treatment on, and prescribe medicine or therapy to me or my dependent after I have been informed of the recommendations. I further authorize the doctor to choose and employ such assistance as he/she deems fit.

☐ I understand the use of anesthetic agents embodies a certain risk including allergic reaction.

☐ It is my responsibility to be aware of my insurance coverage, policy provisions, exclusions, and limitations. This information is furnished to me by my insurance carrier.

☐ University Dental Group staff will perform a complimentary benefits check for me but can only provide an estimate of expected insurance payment.

☐ The responsibility for payment for all dental services provided is mine. Insurance claims may be filed for me but I am responsible for payment of any and all uncovered or partially covered services.

☐ There is a $25.00 service fee if my check is returned for non-payment by the bank.

☐ There is a minimum $25.00 fee charged for a missed appointment or an appointment canceled with less than 24 hours notice.

☐ I understand that all x-rays and diagnostic aids are the property of University Dental Group, P.L. and that copies, if requested, will be made available to me for a reasonable fee as set by this office.

Sign Name (Re-type Name) * **Date** *