Union Dental Center
H. Brett Friedman, DDS
201 South Union Avenue
Havre de Grace, MD 21078
410.939.3950

Since the cause of dental disease is a combination of many factors, and is very complex, it is necessary to investigate any possible contributing influences. The success of your treatment depends on the control of all causative factors. Please answer all the questions to the best of your ability. All responses are confidential.

Patient's Name: _____ Date: _____
Home Address: _____
Home Phone: ( ) _____ Work Phone: ( )_____ Cell Phone: ( ) _____
Best Daytime #: ❑Home ❑Work ❑Cell ❑Minor ❑Single ❑Married ❑Divorced ❑Widow
E-mail Address: _____ Referred by: _____
Birth Date: _____ SSN: _____ College Student: ❑ Yes ❑ No ***(Please present student ID)***
Employer's Name: _____ Occupation: _____
In Case of Emergency, contact: _____ Phone Number: _____

RESPONSIBLE PARTY FOR ACCOUNT ***(If different from above)***

Name: _____ Relationship to Patient: _____ Birth Date: _____
Address: _____
Home Phone: ( )_____ Work Phone: ( )_____ Cell Phone: ( )_____
Best Daytime #: ❑ Home ❑Work ❑Cell Employer: _____ SSN: _____

PRIMARY INSURANCE INFORMATION

Policy Holder: _____ SSN/ID #:_____ Birth Date: _____
Employer: _____Insurance Company: _____ Group: _____

MEDICAL HISTORY

1. Are you under the care of a Physician? ☐ Yes ☐ No If so, explain? _____
   Name: _____ Phone: _____ Last visit: _____
2. What medications, vitamins or herbal remedies are you currently taking? _____
3. ARE YOU TAKING ANY BLOOD THINNERS? ❑Yes ❑ No Name: _____
4. Do you smoke or use tobacco products? ❑Yes ❑ No How much? _____ How often? _____

❑ Acid Reflux
❑ Allergies (seasonal)
❑ Alcohol Abuse
❑ Anemia
❑ Arthritis
❑ Artificial Joints
❑ Artificial Heart Valve
❑ Asthma
❑ Breathing Problems
❑ Bruise Easily
❑ Cancer
❑ Chemotherapy
❑ Chest Pain
❑ Congenital Heart Defect
❑ Depression/Anxiety
❑ Diabetes
❑ Dizziness/Light Headed
❑ Eating Disorder(s)
❑ Emphysema
❑ Endocarditis
❑ Epilepsy
❑ Excessive Bleeding
❑ Fainting
❑ Frequent Headaches
❑ Glaucoma
❑ Hepatitis A, B, C
❑ High Blood Pressure
❑ High Cholesterol
❑ HIV+/AIDS
❑ Illegal Drug Use
❑ Kidney Problems
❑ Liver Problems
❑ Low Blood Pressure
❑ Pace Maker
❑ Radiation Therapy
❑ Seizures
❑ Sickle Cell Disease
❑ Sinus Problems
❑ Sleep Apnea
❑ Stomach Problems
❑ Stroke
❑ Shortness of Breath
❑ Serious Illness(s)
❑ Thyroid Problems
❑ Tuberculosis
❑ Tumor(s)/Growth(s)
❑ Venereal Disease(s)
❑ Yellow Jaundice
❑ Heart Condition
❑ Fever Blist/Cold Sores

Drug Allergies

❑ Aspirin
❑ Codeine
❑ Dental Anesthetic
❑ Erythromycin
❑ Jewelry/Metals
❑ Latex
❑ Penicillin
❑ Sulfa Drugs
❑ Tetracycline
❑ _____

FEMALES: Pregnant ❑ Yes ❑ No # weeks: _____ ❑ Birth Control Pills ❑ Breast Feeding

DENTAL HISTORY

1. Are your gums swollen and/or irritated? ---------- ❑ Yes ❑ No
2. Does your jaw ever click and/or pop on opening or closing? ---------- ❑ Yes ❑ No
3. Have you ever had any serious problems associated with previous dental treatment? ---------- ❑ Yes ❑ No

   If so, explain _____

Please check any of the following that apply to you:

- ❑ Sensitivity (hot, cold, or sweets)
- ❑ Headaches, earaches, neck pain
- ❑ Jaw joint pain
- ❑ Broken teeth or fillings
- ❑ Bleeding, swollen or irritated gums
- ❑ Loose, tipped or shifting teeth
- ❑ Bad breath or taste

"If I could change my smile, I would" . . . . .

- ❑ Make them whiter
- ❑ Make them straighter
- ❑ Close the spaces in between them
- ❑ Replace black metal fillings with tooth colored fillings
- ❑ Repair chipped teeth
- ❑ Replace missing teeth
- ❑ Replace old crowns that do not match
- ❑ Have a smile makeover

Do you have any dental disease(s), condition(s) or problems not listed above that we should know about? If so, explain _____

Do you have or have you had any of the following:

- ❑ Implants
- ❑ Full Dentures
- ❑ Partial Dentures
- ❑ Braces
- ❑ Gum Treatments

On a scale of 1 to 10, with 10 being the highest rating:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your dental visit today? _____

_____

_____

_____

Please share the following dates:

Your last hygiene visit: _____/_____
Your last oral cancer screening: _____/_____
Your last complete x-rays: _____/_____
Previous dentist: _____
City: _____ State: _____

What is the most important thing to you about your future smile and dental health?

_____

_____

_____

_____ _____
Patient's Signature Date

_____ _____
Clinician's Signature Date

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Taking care of you and your family is our highest priority. Our team is committed to your overall health and the success of your treatment. Just as we are committed to providing you with the very best dentistry has to offer, so are we committed to making dentistry financially comfortable for you and your family. That is why, when it comes to talking about finances, our goal is to ensure you have a complete understanding of your estimated financial responsibility and the payment options available to you at Union Dental Center (UDC).

ABOUT OUR FEES

Just one of the many things you will come to expect from us at UDC is your written financial estimate. We never perform, before we inform! Please understand that we strive to provide you with the best ***written estimate*** of your expected fees. Because dentistry is a science, the need for alternative or additional procedure(s) sometimes arises during an appointment. Should this occur, we will discuss any additional costs with you prior to beginning treatment.

YOUR INSURANCE SAVINGS

Dental insurance was designed to assist you with your dental expenses, not to offer comprehensive coverage like most medical plans. By maximizing your benefits we are able to save you money.

We will accept assignment of benefits and file your insurance claims. It's hassle-free at UDC! It is important, however, that you understand that your benefits are negotiated between your employer and insurance company. Therefore, some, or perhaps all, of the treatment you choose to have completed may be non-covered services under the policy your employer has selected. We will always provide you with a ***written estimate*** of your expected fees. Any procedures not covered by your insurance benefits are your responsibility.

MISSED OR CANCELLED APPOINTMENTS

Please help us serve you and our other patients better by keeping your scheduled appointments. Appointments that are missed or changed with less than 24-hours notice are then unavailable to other patients. ***A fee of $50-hour will be charged for appointments that are missed or changed with less then 24-hours notice.***

Thank you for taking time to read our financial agreement. If you have any questions or concerns, please do not hesitate to ask any one of our team members.

PLEASE PICK YOUR PLAN

☐ **Premium Plan:** We know that not all of our patients enjoy insurance benefits. ***For those without insurance, we extended an 8% courtesy on all services for payment in full at the time of service.***

☐ **Silver Plan:** We want you to know that seniority matters to us! ***We extend a 10% courtesy to our 65+ patients that have no dental benefits when they pay in full by cash or check at the time of service.***

☐ **Insurance Savings Plan:** We are happy to assist you in any way we can with your benefits. We will submit your claims and work with your insurance company to maximize your benefits. Please ask us if you would like for us to pre-determine your recommended treatment. We would be happy to do it! ***We do require your co-pay and deductible be paid in full at the time of service.***

☐ **Predicable Payment Plan:** Payments may be perfect for you and we may be able to help. We can make special arrangements based on your needs. **Please ask our Financial Coordinator for assistance.** She would be happy to help!

I have read and fully understand my financial obligations. I understand that any insurance estimate given is **not** a guarantee of actual insurance payment and/or coverage. I understand that any insurance claim not paid in full after 60 days will become my responsibility. Additionally, by signing this form I authorize UDC to process credit card transactions by me either by mail or phone and I authorize my credit institution to pay. I understand that in the event my account becomes delinquent, I will be responsible for any billing charges, finance charges, collection fees, legal fees and/or other charges incurred to collect this account.

I assign directly to UDC all insurance benefits, if any, otherwise payable to me for services rendered. I authorize and release information and payment of my dental benefits directly to the practice. 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. UDC may use my health care information and may disclose such information to my insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Responsible Party: _____ **Signature:** _____ **Date:** ____/____/____

(Please Print) ***(Responsible Party)***