

ORAL AND MAXILLOFACIAL SURGICAL AFFILIATES, P.A.
ANTHONY P. URBANEK, D.D.S., M.D., M.S.

2009 Mallory Lane ▪ Suite 220 ▪ Franklin, TN 37067

<hr/>				<hr/>	
FIRST NAME	M.I.	LAST NAME	EMAIL ADDRESS		
<hr/>			<hr/>		
PREFERRED NAME			DATE OF BIRTH		
<hr/>			<hr/>		
GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			AGE		
<hr/>			<hr/>		
HOME ADDRESS	CITY	ST	ZIP CODE	PATIENT'S SOCIAL SECURITY #	
<hr/>				<hr/>	
PATIENT'S EMPLOYER				HOME TELEPHONE	
<hr/>				<hr/>	
SPOUSE'S/ GUARDIAN'S NAME				WORK TELEPHONE	
<hr/>				<hr/>	
SPOUSE'S/ GUARDIAN'S EMPLOYER				MOBILE TELEPHONE	
<hr/>				<hr/>	
WHO REFERRED YOU TO OUR OFFICE				HEALTH/DENTAL INSURANCE CO.	
<hr/>				<hr/>	
GENERAL DENTIST (& Office Location)				FAMILY PHYSICIAN (& Office Location)	
<hr/>				<hr/>	
CHIEF COMPLAINT: _____					
(REASON FOR THIS VISIT) _____					

PAST MEDICAL HISTORY

OPERATIONS: _____

HOSPITALIZATIONS: _____
(OTHER THAN FOR AN OPERATION)

ILLNESSES: _____

ALLERGIES: _____
(MEDICATIONS/ANTIBIOTICS)

MEDICATIONS: _____

- Please indicate with check if you have had any of the following:**
- | | | |
|--|---|---|
| <input type="checkbox"/> PSYCHIATRIC TREATMENT | <input type="checkbox"/> SHORTNESS OF BREATH | <input type="checkbox"/> JAUNDICE |
| <input type="checkbox"/> SMOKER: PACKS PER DAY | <input type="checkbox"/> WHEEZING | <input type="checkbox"/> HEPATITIS |
| <input type="checkbox"/> DRUG/ALCOHOL ABUSE | <input type="checkbox"/> COUGHING BLOOD | <input type="checkbox"/> CIRRHOSIS |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> NIGHT SWEATS | <input type="checkbox"/> STOMACH ULCERS |
| <input type="checkbox"/> SKIN DISEASE | <input type="checkbox"/> BRONCHITIS | <input type="checkbox"/> PAIN ON URINATION |
| <input type="checkbox"/> ENLARGED LYMPH NODES | <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> BLOODY URINE |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> PNEUMONIA | <input type="checkbox"/> KIDNEY DISEASE |
| <input type="checkbox"/> MUSCLE WEAKNESS | <input type="checkbox"/> ASTHMA | <input type="checkbox"/> COMPLICATION OF PREGNANCY |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> RAPID HEART RATE | <input type="checkbox"/> MENSTRUAL PROBLEMS |
| <input type="checkbox"/> BLEEDING PROBLEMS | <input type="checkbox"/> IRREGULAR HEART RATE | <input type="checkbox"/> PROSTATE DISEASE |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> CHEST PAIN | <input type="checkbox"/> VENEREAL DISEASE |
| <input type="checkbox"/> THYROID DISEASE | <input type="checkbox"/> ANKLE SWELLING | <input type="checkbox"/> EPILEPSY |
| <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> PARALYSIS |
| <input type="checkbox"/> FAINTING | <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> NERVOUS ILLNESS |
| <input type="checkbox"/> EAR PAIN | <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> CANCER |
| <input type="checkbox"/> DEAFNESS | <input type="checkbox"/> STROKE | <input type="checkbox"/> PROBLEMS WITH ANESTHETICS |
| <input type="checkbox"/> SINUSITIS | <input type="checkbox"/> WEIGHT CHANGE | <input type="checkbox"/> IF FEMALE, ARE YOU PREGNANT? |
| <input type="checkbox"/> NASAL OBSTRUCTION | <input type="checkbox"/> VOMITING BLOOD | |

SIGNATURE: _____ **DATE:** _____

INSURANCE INFORMATION

ARE YOU A STUDENT? _____ YES _____ NO

MEDICAL INSURANCE CARRIER NAME _____

IDENTIFICATION # _____

GROUP # _____ GROUP NAME (EMPLOYER) _____

IS THE INSURANCE PLAN THROUGH SOMEONE ELSE OTHER THAN THE PATIENT?
(EXAMPLE: WIFE, HUSBAND, PARENT)

_____ YES _____ NO

IF "YES":

WHAT IS THEIR NAME? _____

WHAT IS THEIR DATE OF BIRTH? _____

WHAT IS THEIR SOCIAL SECURITY NUMBER? _____

WHO IS THEIR EMPLOYER? _____

WHAT IS THEIR ADDRESS, IF DIFFERENT THAN YOURS?

DENTAL INSURANCE CARRIER NAME _____

IDENTIFICATION # _____

GROUP # _____ GROUP NAME (EMPLOYER) _____

IS THE INSURANCE PLAN THROUGH SOMEONE ELSE OTHER THAN THE PATIENT?
(EXAMPLE: WIFE, HUSBAND, PARENT)

_____ YES _____ NO

IF "YES":

WHAT IS THEIR NAME? _____

WHAT IS THEIR DATE OF BIRTH? _____

WHAT IS THEIR SOCIAL SECURITY NUMBER? _____

WHAT IS THEIR ADDRESS, IF DIFFERENT THAN YOURS?

(SECONDARY INSURANCE INFORMATION SHOULD BE LISTED ON NEXT PAGE)

SECONDARY INSURANCE INFORMATION

SECONDARY MEDICAL INSURANCE CARRIER NAME _____

IDENTIFICATION # _____

GROUP # _____ **GROUP NAME (EMPLOYER)** _____

IS THE INSURANCE PLAN THROUGH SOMEONE ELSE, OTHER THAN THE PATIENT?
(EXAMPLE: WIFE, HUSBAND, PARENT)

_____ **YES** _____ **NO**

IF "YES":

WHAT IS THEIR NAME? _____

WHAT IS THEIR DATE OF BIRTH? _____

WHAT IS THEIR SOCIAL SECURITY NUMBER? _____

WHO IS THEIR EMPLOYER? _____

WHAT IS THEIR ADDRESS, IF DIFFERENT THAN YOURS?

SECONDARY DENTAL INSURANCE CARRIER NAME _____

IDENTIFICATION # _____

GROUP # _____ **GROUP NAME (EMPLOYER)** _____

IS THE INSURANCE PLAN THROUGH SOMEONE ELSE, OTHER THAN THE PATIENT?
(EXAMPLE: WIFE, HUSBAND, PARENT)

_____ **YES** _____ **NO**

IF "YES":

WHAT IS THEIR NAME? _____

WHAT IS THEIR DATE OF BIRTH? _____

WHAT IS THEIR SOCIAL SECURITY NUMBER? _____

WHAT IS THEIR ADDRESS, IF DIFFERENT FROM YOURS?

WELCOME NEW PATIENTS!

FINANCIAL POLICY & SERVICE AGREEMENT

THE FOLLOWING IS OUR FINANCIAL POLICY. THIS POLICY IS ESTABLISHED TO HELP OUR PATIENTS UNDERSTAND THEIR FINANCIAL RESPONSIBILITIES PRIOR TO ANY TREATMENT. IF THERE ARE ANY QUESTIONS, PLEASE DO NOT HESITATE TO ASK.

- We will file claims to your insurance company for covered procedures. The portion which is NOT expected to be paid by your insurance company is payable IN FULL, PRIOR to surgery. Verification of insurance coverage and benefit information for services to be rendered is NOT a “guarantee” of benefits, but an estimate of what your insurance carrier is expected to pay. Actual benefits cannot be determined until the claim has been filed with your insurance company. Any unpaid balance after your insurance claim has been processed is the patient’s responsibility.
- All insurance and financial matters must be discussed with the Insurance/Finance Coordinator PRIOR to surgery.
- Patients who have insurance not accepted by this office may request a copy of the super bill for charges incurred to file with their insurance carrier.
- Patients who do not have insurance are required to pay IN FULL prior to the time of service.
- As well as cash and a personal check, we accept VISA, MASTER CARD, DISCOVER and CARECREDIT. CARECREDIT is like a credit card for medical and dental expenses. There is no annual fee for this option and there are some interest free plans available. You may apply for CARECREDIT in this office with the assistance of the Insurance/Finance Coordinator. This option allows your other credit cards to remain available for other purchases and emergencies.

I HAVE READ, UNDERSTAND, AND AGREE TO THE FINANCIAL POLICY ENFORCED IN THIS OFFICE. I AUTHORIZE THE RELEASE OF ANY MEDICAL RECORDS OR OTHER INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIMS. ASSIGNMENT OF BENEFITS WILL BE MADE TO ORAL AND MAXILLOFACIAL SURGERY AFFILIATES, ANTHONY P. URBANEK, D.D.S., M.D.

Patient Name

Responsible Party Signature

Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPPA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- Contact me regarding my appointment.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand and acknowledge that any photos or other media taken under my verbal consent may be used for promotional use (i.e. Facebook posts, monthly newsletters, printed promotional materials, etc.).

_____ **Initials**

Patient (or Guardian) Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain patient’s signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date	Initials	Reason