ORAL AND MAXILLOFACIAL SURGICAL AFFILIATES, P.A.
ANTHONY P. URBANEK, D.D.S., M.S., M.D.
8119 Isabella Lane ▪ Suite 108 ▪ Brentwood, TN 37027

EMAIL ADDRESS

FIRST NAME **M.I.** **LAST NAME**

DATE OF BIRTH

PREFERRED NAME **GENDER:** ☐ **MALE** ☐ **FEMALE**

AGE

HOME ADDRESS **CITY** **ST** **ZIP CODE**

PATIENT'S SOCIAL SECURITY #

PATIENT'S EMPLOYER

HOME TELEPHONE

SPOUSE'S/ GUARDIAN'S NAME

WORK TELEPHONE

SPOUSE'S/ GUARDIAN'S EMPLOYER

MOBILE TELEPHONE

WHO REFERRED YOU TO OUR OFFICE

HEALTH/DENTAL INSURANCE CO.

GENERAL DENTIST (& Office Location)

FAMILY PHYSICIAN (& Office Location)

CHIEF COMPLAINT: _____
(REASON FOR THIS VISIT)

PAST MEDICAL HISTORY

OPERATIONS: _____

HOSPITILIZATIONS: _____
(OTHER THAN FOR AN OPERATION)

ILLNESSES: _____

ALLERGIES: _____
(MEDICATIONS/ANTIBIOTICS)

MEDICATIONS: _____

Please indicate with check if you have had any of the following:

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

SIGNATURE: _____ **DATE:** _____

INSURANCE INFORMATION

ARE YOU A STUDENT? _____YES _____NO

<u>MEDICAL</u> <u>INSURANCE CARRIER NAME</u> _____

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?

<u>DENTAL</u> <u>INSURANCE</u> 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?

(<u>SECONDARY INSURANCE INFORMATION SHOULD BE LISTED ON NEXT PAGE)</u>

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 RESPONSIBILTIES PRIOR TO ANY TREATEMENT. 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

ORAL AND MAXILLOFACIAL SURGICAL AFFILIATES, P.A.
8119 Isabella Lane, Suite 108 ● Brentwood, TN 37027 ● (615)771-1983

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