urbn dental

2400 Mid Ln, Suite 350
Houston, Tx 77027
Ph: 713-714-4245
Fax:281-516-8296

PATIENT INFORMATION

Patient:

Last name:_____ First Name:_____ DOB:_____

Social Security Number:_____ Relationship Status:_____ Sex: F/M

Address:_____ City, State, Zip Code:_____

Cell Phone:_____ Home Phone:_____

Employer Name:_____ E-mail:_____

How did you hear about us? _____

Parent/Guardian Information *(REQUIRED IF PATIENT IS UNDER 18 YEARS OLD, PATIENT CANNOT ATTEND APPOINTMENTS BY THEMSELVES).*

Last Name:_____ First Name:_____ DOB:_____

Social Security Number:_____

Custody Status: *please indicate joint or sole (mother of father or guardian)*

Address:_____ City, State, Zip Code:_____

Emergency Contact:

First & Last Name:_____ Phone:_____

Relationship:_____ E-mail:_____

Primary Insurance Information *(please provide a copy of insurance card and ID):*

Insurance Company:_____ Group Number: _____

Member ID Number:_____ Effective Dates: From:_____ To:_____

Insured's Information *(if not self):*

Relationship to patient: _____

Last Name: _____ First Name:_____

DOB:_____ Social Security Number:_____

Address:_____

City, State, Zip Code:_____

Secondary Insurance Information *(please provide a copy of insurance card and ID):*

Insurance Company:_____ Group Number: _____

Member ID Number:_____ Effective Dates: From:_____ To:_____

Secondary Insured's Information (if not self):

Relationship to patient: _____

Last Name: _____ First Name:_____

DOB:_____ Social Security Number:_____

Address:_____

City, State, Zip Code:_____

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Patient First and Last Name:_____ **DOB:**_____

Although dental personnel primarily treat the are in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes, please explain:_____
Have you ever been hospitalized or had a major operation? Yes No
If yes, please explain:_____
Have you ever had a serious head or neck injury? Yes No If yes, please explain:_____
Are you taking any medications, pills or drugs? Yes No If yes, please explain:_____
Do you take, or have you taken, Phen-Fen or Redux? Yes No
Are you on a special diet? Yes No
Do you use tobacco? Yes No
Do you use controlled substances? Yes No

Women: Are you.....
Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

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Are you allergic to any of the following?
Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetic
Other: If yes, please explain:_____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Stomach/Intestinal Disease		
Blood Disease	Yes	No	Fainting Spells/Dizziness			Kidney Problems	Yes	No		Yes	No
Blood Transfusion	Yes	No		Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Breathing Problem	Yes	No	Frequent Cough	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Bruise Easily	Yes	No	Frequent Diarrhea	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Cancer	Yes	No	Frequent Headaches	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Chemotherapy	Yes	No	Genital Herpes	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chest Pains	Yes	No	Glaucoma	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Cold Sores/Fever Blisters			Hay Fever	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
	Yes	No	Heart Attack/Failure	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder			Heart Murmur	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
	Yes	No	Heart Pace Maker	Yes	No	Recent Weight Loss	Yes	No			

Have you ever had any serious illness not listed above? Yes No If Yes, please explain:_____
Comments:_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's health). It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian:_____ **Date**:_____

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HIPAA Acknowledgment & Confidential Communication Agreement

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____Date: _____

Print First and Last Name: _____Telephone: _____

If not signed by the patient, please indicate:

Relationship? ☐ Parent or guardian of minor patient
☐ Guardian or conservator of an incompetent patient
☐ Beneficiary of personal representative of deceased patient

Name of Patient: _____

List the **FAMILY MEMBERS** or other persons, if any, with whom we may discuss your dental treatment and/or your diagnosis or in case of emergency:
Name_____ Phone_____
Name_____ Phone_____

List the **EMAIL ADDRESS** which we may send your private health information to:
Email Address: _____
Alternate Email Address: _____

Print the **TELEPHONE NUMBER** where you want to receive calls about appointments, billing and insurance inquiries, or dental healthcare questions:
Telephone Number: _____
May we send **TEXT** messages to this number? Yes_____ No _____
May we leave a message or **VOICE MAIL** to this number? Yes_____ No_____

I understand that this agreement remains in effect until revoked by me in writing. I also understand and consent that URBN Dental share proceeds as part of their arrangement in bringing me excellent dental care.

Print Name:_____

Signature:_____

Date:_____

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Financial Agreement

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

ALL ACCOUNTS ARE DUE AND PAYABLE AT TIME OF SERVICE. If a procedure requires multiple appointments, payment is required in full at the first appointment.

Payment options:

1. Cash 2. Check 3. MasterCard 4. Visa 5. Discover/AMEX

6**. CareCredit**

*CareCredit is a credit card used for medical purposes only. URBN Dental can provide up to **24 months no interest**. Ask us for the details and how to apply.*

7. Credit card authorization for recurring charges:

a. Treatment exceeds $200

b. Plan may not exceed 4 months

Patient with insurance: The PATIENT is responsible for the ESTIMATED non-covered portion, procedures and/or deductibles at the time of the service, OR the patient can sign a credit card authorization to bill their credit card AFTER insurance has paid for the visit. If the insurance company does not pay after 60 days, we will bill you directly for the full balance.

Parents not accompanying their child to an appointment must make PRIOR arrangements for payment (cash, check or credit card authorization).

Parents accompanying their children are financially responsible for payment.

18% annual **interest** is charged for any unpaid balance. A $15 fee is charged for nonpayment.

There is a $30.00 processing charge for **non-sufficient funds** or returned checks.

Records can be viewed at any time. There is a nominal charge for release or copies of records.

Because instruments, chairs, and personnel are reserved exclusively for your appointment, there is a **$25 - $50 CHARGE FOR CHANGED OR BROKEN APPOINTMENTS LESS THAN 48 HOURS IN ADVANCE**.

I, _____, agree to these financial terms.

Signature _____ Date_____

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Social Media Release Form

I _____, hereby authorize URBN Dental or any of their assignees to take photographs, slides, and videos included but not limited to, my teeth, jaws, and face. I understand that the photographs, slides, and videos will be used as a record of my care, and may be used for communication with other health care professionals, educational publications (dental journals), and educational lectures. The content may also be used for advertising purposes (including website publication, facebook posts, snapchat, Instagram, etc). I further understand that if the photographs, slides, and videos are used in any publication or as a part of a demonstration. I do not expect compensation, financial or otherwise, for the use of these photographs. If I wish to revoke this consent, I may do so in writing.

If declining this consent, leave blank.

Please initial one option:

_____I do not mind if my photographs are used in any of the above stated situations.

_____I only agree to have my teeth shown without any identifying features.

Signed_____Date_____