Viviana P. Urban D.D.S.

Michael J. Urban D.D.S., P.A.

Today's date :

Patient Registration Form

Last name: **First name:** **M.I:** **Birth date: / /**

If Patient is Minor Guardian Last Name: **First name:** **Birth date / /**

Address: **City:**

State: **Zip code:** **Male[ ] Female[ ] Single [ ] Married:[ ] Widowed[ ]**

Home Phone No.: **Cell No.:** **Work No. :**

Social Security Number: **Email for confirmation:**

Insurance Information

Insurance Company: **Insurance address:**

Policy holder name: **Policy holder SSN:**

Policy holder DOB: / / **Patient DOB: / /**

Policy holder employer name: **Group No.:**

Subscriber ID:

Do you have secondary Insurance?

Person Financially Responsible for the Account

Name: **Relationship to the patient :** **SSN:**

Date of birth / / **Address: (if different from Pt)**

Email address: **Cell No. :** **Work No.:**

Getting to know you

Is another member of your family or relative a patient at our office?

Referred to us by: **Patient Name** **Clipper [ ] Practice Website [ ] Insurance website [ ] Other [ ]**

Person to contact for Emergency : **Phone No.:**

What are your preferred appointment times?: **Morning: _____ Afternoon_____**

Monday_____Tuesday_____Wednesday_____Thursday_____Friday_____

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Concerning Insurance

We are participating dentists for many insurance plans. The patient is responsible for following the proper guidelines established by his/her insurance carrier.

Patients covered by dental insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. As a courtesy to you, we will file your claims with your insurance carrier at the time of service. You will be billed your insurance copayment amount and deductible at the time that the services are rendered based on an estimate of coverage provided by your insurance carrier. If there are any additional charges that are not covered by insurance, you will be billed accordingly.

The insurance coverage information given by staff is only an estimate based on the information provided by your insurance company. This does not guarantee coverage or inform us of any limitations or exclusions in your plan. Please read the booklet provided by your insurance company for these. All insurance payment estimates are based upon the information given to us by you and the insurance company.

I understand this is an estimate and my insurance may or may not provide coverage. _____(initial)

I also understand any balance remaining will be my responsibility _____(initial)

Even though than an insurance claim is filed, you will receive a statement each month if your account has a balance due. This office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. We will contact your insurance carrier if we have not received payment; however, any balance outstanding after 60 days is your responsibility.

Authorization to release and assign insurance benefits: I authorize release of any information required to act on any insurance claim and permit photographic or other facsimile reproduction of this authorization to be used in the place of the original assignment. I hereby assign Dr. Viviana P. Urban D.D.S., Michael J. Urban D.D.S, P.A. for any services furnished to me or my dependents by that provider. This authorization is in effect for all future claims, until I choose to revoke it.

Patient Signature_____ Date_____

If Minor Guardian Signature_____ Relationship to Patient_____ Date_____

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Consent for Treatment

1. I authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by Doctor Urban to make a thorough diagnosis of (name of patient) _____'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a compete recital of any possible complications.
4. Lastly, I agree to be responsible for payment on my behalf or my dependents. I understand that if I provide incorrect or expired insurance information, I will assume full financial responsibility for all charges incurred. I understand if that my co-pay is not paid at the time of service or if there is a balance due after insurance and I have been billed this balance, there will be a $15 repeat billing fee for every month the balance is not paid. I understand that the payment is due at the time of services unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. I understand that there will be a $35 fee for returned checks.
5. I understand that I am responsible for any additional charges incurred if my account goes to collection.
6. I understand there is a broken appointment fee based on time reserved if I fail to notify the office within 48 business hours of a scheduled appointment. I understand this cancellation notice is necessary to provide the office staff sufficient time to give the appointment time to another patient. Voicemail notifications left over the weekend do not meet the advanced notification requirement for Monday appointments. The fee for late cancellation or missed dental appointments is $50 per hour reserved which must be paid before the next appointment can be scheduled.

By my signature, I certify that the information provided on my patient registration form and regarding my insurance coverage is correct and acknowledge that I have read and understand the above consent, financial, and cancellation policies.

Patient signature: _____ Date _____Witness _____

Or Responsible Party Signature _____ Relationship to Patient _____Date_____

Photography Release

I, _____ consent to agree for intra-oral images of my mouth to be shared with other

professionals or patients to educate and explain dental procedures and possible results of treatment.

Patient signature _____ Date_____