JEFFREY URBAN DMD
WHERE HEALTHY SMILES BEGIN

Welcome to Our Office!

Our Mission is to be a Dental Team committed to bringing State of the Art Dentistry in total comfort, respect, and serenity to our patients. We strive at all times to create positive relationships with our patients, as well as within our team, thereby, in our own way, enriching our community.

Patient Information

Name: Mr. Mrs. Ms. _____ _____ Today's Date_____
First *MI* *Last*

What would you like us to call you? (Preferred Name)_____

Street Address_____

City_____State_____Zip_____

Phone # (Home)_____(Cell)_____(Work)_____

E-mail Address_____

How would you like us to confirm your appointments?
□ E-mail □ Call at home □ Call at work □ Call on cell

Social Security Number_____ Date of Birth_____

Marital Status: □ Single □ Married □ Divorced □ Widowed

Whom may we contact in case of emergency? _____Phone #_____

Whom may we thank for referring you or how did you hear about us? _____

Tell Us About You… The better we understand you, the better we can serve you. We don't like to make assumptions or guess about what makes you happy. Please place an ***X*** along each line indicating which way your opinion or preference leans.

I tend to look at the details _____ I tend to look the big picture

I prefer long-lasting solutions that may cost more _____ I prefer more temporary solutions at lower cost

My insurance largely determines the extent of my care _____ I largely determine the extent of my care

Consent for Services and Billing

●To the best of my knowledge, the information above is correct. I realize that Jeffrey Urban DMD, LLC will provide insurance billing and assist with insurance benefits to the best of their knowledge; however, all charges for services and collection cost for untimely payments are ultimately my responsibility.
●I understand all co-pays, costs for non-covered services and all fees if uninsured are to be paid at the time of service.
●I grant my permission to be telephoned at home, work or cell to discuss matters related to this form.

_____ Date_____ Relationship to Patient_____
Signature of Patient/Guarantor of Payment/Responsible Party

Primary Insurance and/or Person Responsible for Payment

Name: Mr. Mrs. Ms. _____

If Different from Patient Information:
Street Address_____

City_____ ***State***_____ ***Zip***_____

Social Security Number _____ ***Date of Birth***_____

Drivers License Number_____

Employer Name_____Occupation_____

Employer Address_____

Insurance Company_____ Insurance Phone_____

Group Number_____ Contract Number_____

Patient's relationship to insured/responsible party? □ Self □ Spouse □ Child □ Other_____

Spouse and/or Secondary Insurance

Name: Mr. Mrs. Ms. _____

If Different from Patient Information:
Street Address_____

City_____ ***State***_____ ***Zip***_____

Social Security Number _____ Date of Birth_____

Employer Name_____Occupation_____

Employer Address_____

Insurance Company_____ Insurance Phone_____

Group Number_____ Contract Number_____

Patient's relationship to insured/responsible party? □ Self □ Spouse □ Child □ Other_____

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Medical History

Today's Date_____

Name: Mr. Mrs. Ms. _____ Date of Birth_____
First MI Last

General Health: ❑ Excellent ❑ Good ❑ Fair Date of last physical _____

Physician's Name _____ Phone _____

Are you currently under medical treatment?..... ❑ Yes ❑ No

If yes, please explain: _____

Are you currently taking any medications or herbal supplements?..... ❑ Yes ❑ No

If **yes**, please list medications and herbal supplements: _____

_____

Have you ever taken Fosamax, Actonel, Aredia, Boniva or Zometa (bisphosphonates)? ❑ Yes ❑ No

Are you on a special diet?..... ❑ Yes ❑ No

Have you lost or gained more than 10 pounds in the past year?..... ❑ Yes ❑ No

Do you use any form of tobacco:……..... ❑ Yes ❑ No

What Form?_____How Much?_____

Are you interested in quitting?..... ❑ Yes ❑ No

Women --- (Please check)

Are you: ❑ Pregnant ❑ Nursing ❑ On Hormone Therapy ❑ On Birth Control Medication?

Has a Physician ever informed you that you have or have had any of the following?

Rheumatic Fever……	❑ Yes	❑ No	Asthma/Respiratory Disease…….	❑ Yes	❑ No
Heart Murmur……	❑ Yes	❑ No	Intestinal Disease…….....	❑ Yes	❑ No
Mitral Valve Prolapse……	❑ Yes	❑ No	Cancer……	❑ Yes	❑ No
Other Heart Ailment……..	❑ Yes	❑ No	Chemo/Radiation Therapy…….	❑ Yes	❑ No
Artificial Joints……..	❑ Yes	❑ No	Liver Disease…….....	❑ Yes	❑ No
Arthritis…….	❑ Yes	❑ No	Kidney Disease…….	❑ Yes	❑ No
HIV or AIDS…….	❑ Yes	❑ No	Diabetes……	❑ Yes	❑ No
Pacemaker…….	❑ Yes	❑ No	Stroke……	❑ Yes	❑ No
High/Low Blood Pressure..	❑ Yes	❑ No	Mental Health Disorder		
Fainting Spells……...	❑ Yes	❑ No	_____……	❑ Yes	❑ No
Epilepsy/Seizures……..	❑ Yes	❑ No	Caffeine Dependency……	❑ Yes	❑ No
Head Injuries…….	❑ Yes	❑ No	Drug/Alcohol Dependency……..	❑ Yes	❑ No
Blood Disorder……..	❑ Yes	❑ No	Organ Transplant……..	❑ Yes	❑ No
Latex Sensitivity……	❑ Yes	❑ No	Shingles……	❑ Yes	❑ No
Severe Headaches…….	❑ Yes	❑ No	Sinus Problems…….	❑ Yes	❑ No
Fever Blisters/Cold Sores.	❑ Yes	❑ No	Thyroid (Hyper/Hypo)…….	❑ Yes	❑ No
			Tuberculosis……..	❑ Yes	❑ No

Have you had any x-rays taken of any part of your body within the last year? _____

Can you use mouthwash with alcohol? _____

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Are you **ALLERGIC** to any of the following?

Aspirin	❑ Yes	❑ No	Latex	❑ Yes	❑ No
Codeine	❑ Yes	❑ No	Metals	❑ Yes	❑ No
Dental Anesthetics (e.g. Novocaine)	❑ Yes	❑ No	Penicillin	❑ Yes	❑ No
Erythromycin	❑ Yes	❑ No	Tetracycline	❑ Yes	❑ No
Sulfa Drugs	❑ Yes	❑ No	Other Medication_____		

Signature of Patient, Parent or Guardian

Medical History Summary

Updates