- PATIENT INFORMATION SHEET - Date: _____

PATIENT: (Mr., Mrs., Ms.) First Name: _____ Middle Initial: ____ Last Name: _____

Sex: ❑ Male ❑ Female Date of Birth: _____ Age: _____ Social Security No.: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Home Tel.: (_____) _____ Bus. Tel: (_____) _____

Cell #.: (_____) _____ Emergency Contact #: (_____) _____

Physician: _____ Dentist: _____

Referred By: _____

Student: Full time ❑ Part Time ❑ School Name: _____

Married ❑ Divorced ❑ Legally Separated ❑ Widow ❑ Single ❑ _____

Employed: Full Time ❑ Part Time ❑ Retired ❑ Unemployed ❑

Person responsible for your account? Relation: ❑ Self ❑ Spouse ❑ Mother ❑ Father ❑ _____

Name: _____ Date of Birth: _____

Soc. Sec. #: _____ Home Tel.: (_____) _____ Cell Phone: (_____) _____

Street: _____ City: _____ State: ____ Zip: _____

Employer: _____ Tel.: (_____) _____

Please specify the reason for today's visit: _____

EMPLOYER INFORMATION:

Name: _____ Tel. # (_____) _____

Street: _____ City: _____ State: _____ Zip: _____

FEES AND PAYMENTS:

We make every effort to keep the cost of your oral surgical care as low as possible. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. Interest charges of 1.5% per month (18% Annually) will be applied to accounts over 60 days old.

I understand that if my account is sent to a collection agency, my account will be charged with a 40% collection fee. I understand that should legal action be taken in an effort to collect on said account, I will be completely responsible for all legal costs, including filing fees, court costs and attorneys fees.

This signature on file is also my authorization for the release of information necessary to process my claim. I hereby authorize payment directly to the surgeon named of the benefits otherwise payable to me.

Date _____

STOP! DETACH TOP SHEET ONLY AND BRING TO FRONT DESK BEFORE PROCEEDING

Signature: _____