

— PATIENT INFORMATION SHEET —

Date: _____

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

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

Street: _____

City: _____ State: _____ Zip: _____

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

Physician: _____ Dentist: _____

Referred By: _____

Have you or any of your family members been here before? _____

Who will be responsible for your account? Relation: Self Spouse Mother Father _____

Name: _____ Home Tel.: (_____) _____

Signature: _____ Social Security No.: _____ Work Tel.: (_____) _____

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

Employer: _____ Tel.: (_____) _____

Student: Full Time Part Time Not School Name/Address: _____Married Divorced Legally Separated Widow Single _____Employed: Full Time Part Time Retired Not Do you belong to a Preferred Provider Organization? Yes No**PRIMARY INSURANCE COMPANY:****INSURED PARTY:**

Name: _____ Name: _____

Address: _____ Relation to Insured: Self Spouse Child Other

Phone (_____) _____ Date of Birth: _____

Does your plan cover: Dental Medical Both Street: _____

Group No.: _____ Group Name: _____ City, State, Zip: _____

Local: _____ Phone: Home: (_____) _____ Work: (_____) _____

EMPLOYER INFORMATION:

Social Security No.: _____

Name: _____

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

Is this an Employer Health Insurance Plan? Yes No Employer ID No.: _____**SECONDARY INSURANCE COMPANY:****INSURED PARTY:**

Name: _____ Name: _____

Address: _____ Relation to Insured: Self Spouse Child Other

Phone (_____) _____ Date of Birth: _____

Does your plan cover: Dental Medical Both Street: _____

Group No.: _____ Group Name: _____ City, State, Zip: _____

Local: _____ Phone: Home: (_____) _____ Work: (_____) _____

EMPLOYER INFORMATION:

Social Security No.: _____

Name: _____

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

Is this an Employer Health Insurance Plan? Yes No Employer ID No.: _____**FEES AND PAYMENTS:**

We make every effort to keep down the cost of your oral surgical care. 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 at the top of the 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. Any account over 90 days will be charged a 1½% finance charge monthly with an annual rate of 18%. I agree that my account will be debited electronically for both face amount and returned check fees if returned unpaid.

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