

PATIENT FULL LEGAL NAME (Dr., Mr., Mrs., Ms.) _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____ SS#: _____

BIRTH DATE: _____ AGE: _____ SEX: _____ HOME () _____ WORK () _____ EXT _____

CELL OF RESPONSIBLE PARTY: () _____ EMAIL: _____

EMPLOYER: _____ MARITAL STATUS: S M W D

PERSON TO CONTACT IN CASE OF EMERGENCY: _____

RELATION TO PATIENT: _____ PHONE# _____

WHO REFERRED YOU TO OUR OFFICE? _____ WERE X-RAYS SENT? YES/ NO

GENERAL DENTIST: _____ PHONE () _____

MEDICAL PHYSICIAN: _____ PHONE () _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT? _____

ADDRESS: _____

RELATION: _____ HOME PHONE () _____ WORK PHONE () _____

EMPLOYER: _____ SS#: _____

Privacy Policy: The Oral Facial Surgery Institute is committed to obeying all federal, state, local laws, and regulations regarding Privacy Practices. Information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual.

Financial Policy: If you do not have medical/dental insurance, payment in full is expected at the time of service. If you have medical/dental insurance we will file all claims to both primary and secondary carriers on your behalf. Please remember you are responsible for all deductibles, co-pays and non-covered charges at the time of service. We accept payments by cash, check and all major credit cards. We also offer free financing through Care Credit and Wells Fargo for those approved. You will receive billing statements from our offices for all remaining account balances that are deemed patient responsibility, this balance is due within 15 business days. If the balance is not paid in full in a timely manner, collection efforts will be made. Any collection agency fees incurred will be at the patient's expense.

I have read and understand the above Notice of Privacy Practices. Also, I agree and understand the above Financial Policy and understand that charges, co-pays and deductibles not covered by my insurance company may be my responsibility.

PATIENT'S (or Guardian's) SIGNATURE _____ DATE _____