

## PATIENT

Name: Mr. Mrs. Ms. \_\_\_\_\_ Nickname: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Street Address (if different): \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Social Security: \_\_\_\_\_

Sex:  Male  Female Marital Status:  Single  Married  Divorced  Widowed

Spouse's Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Are you a student?  Full  Part School Name, State: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Who were you referred by? Physician: \_\_\_\_\_ Dentist: \_\_\_\_\_

Orthodontist: \_\_\_\_\_ Other:  Friend  Phone Book  Insurance Company  Web

## RESPONSIBLE PARTY (if other than patient)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Social Security: \_\_\_\_\_

Relationship to the patient: \_\_\_\_\_ Marital Status:  Single  Married  Divorced  Widowed

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

## INSURANCE (Please present medical/dental cards for photocopy)

### Primary Company

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Group #: \_\_\_\_\_ ID #: \_\_\_\_\_

Policy Owner: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Medical  Dental  Auto  Other: \_\_\_\_\_

### Secondary Company

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Group #: \_\_\_\_\_ ID #: \_\_\_\_\_

Policy Owner: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Medical  Dental  Auto  Other: \_\_\_\_\_

We make every effort to keep down the cost of your surgical care. It is our policy to collect for any services under \$100.00. Other arrangements can be made with our Financial Coordinator 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 medical and/or dental insurance, we will be glad to assist you in claim filing on your behalf; please complete the identifying information.

Please remember that insurance is considered a method of assisting in patient care 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 by your insurance company. Past due balances are subject to a monthly finance charge.

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_