Patient Information

Date_____

Patient Name_____
Last First Middle

Address_____
Street City State Zip

Home Phone_____ Cellular_____ Date of Birth_____ Social Security #_____

If patient is a minor, parent or guardian's name_____

Referring Dentist_____ Patient's Physician _____

Email Address:_____

Responsible Party Information

Name_____
Last First Middle

Residence_____
Street City State Zip

Mailing Address_____
Street City State Zip

How long have you lived at this address_____ Home Phone_____ Work Phone _____

Previous address (if less than 3 years) _____
Street City State Zip

Social Security #_____Date of Birth _____ Relationship to Patient_____

Employer_____ Position_____ No. Years Employed_____

Insurance Information

Insured's Name_____ Insured Social Security #_____

Insurance Company_____ Identification #_____Group #_____

Insurance Company Address_____
Street City State Zip

Insured's Employer_____

Do you have dual coverage? Yes ☐ No ☐ If yes, please provide the following for secondary:

Insured's Name_____ Insured Social Security #_____

Insurance Company_____ Identification #_____Group #_____

Insurance Company Address_____
Street City State Zip

Insured's Employer_____

Emergency Information

Name of person in case of an emergency_____ Phone Number_____

Address of emergency contact_____
Street City State Zip

I understand that I am personally responsible to pay all collections fees associated with my account, including reasonable attorney fees and reasonable agency fees. I understand that in the event my account is turned over to a third party collection agency, a collection fee in the amount of up to 50% of my total account balance will be added to my balance and that I am responsible to pay that amount.

I give my permission to Oral Surgical Associates to disclose my personal data for treatment, account balance resolution, and other health care operations to appropriate agencies. I also agree to allow the exchange of consolidation of information with non-medical goods or services providers for the HIPA Privacy Act. A copy of this information is available upon your request.

There will be a 1.5% interest charge on balances over 60 days

Signature_____ Date_____