OMS SPECIALISTS
ORAL, MAXILLOFACIAL & IMPLANT SURGERY

Patient Information **Date** _____

Legal Name _____ Sex M F Birthdate _____

Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ - _____ Cell Phone (_____) _____ - _____ Work Phone (_____) _____ - _____

Email Address _____

Marital Status: Single Married Divorced Widowed Spouse Name _____

Dentist/Orthodontist _____ How did you hear about us? _____

Pharmacy_____ **Street** _____ **City**_____

Billing/Responsible Party (*if other than patient*)

Relationship to Patient: Self _____ Spouse _____ Parent _____ Other _____

Name _____ Sex M F Birthdate _____

Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ - _____ Cell Phone (____) _____ - _____ Work Phone (____) _____ - _____

Primary Insurance Information *(please complete each line to ensure your insurance is billed correctly)*

Relationship to Patient: Self _____ Spouse _____ Parent _____ Other _____

Subscriber/Insured Person _____ Social Security # _____

Address (if different from above) _____ City _____ State _____ Zip _____

Home Phone (_____) _____ - _____ Cell Phone (_____) _____ - _____ Work Phone (_____) _____ - _____

Birthdate _____ Employer _____

Dental Insurance Co. _____ Subscriber ID _____ Group # _____

Medical Insurance Co. _____ Subscriber ID _____ Group # _____

Secondary Insurance Information (*if applicable*)

Relationship to Patient: Self _____ Spouse _____ Parent _____ Other _____

Subscriber/Insured Person _____ Social Security # _____

Address (if different from above) _____ City _____ State _____ Zip _____

Home Phone (_____) _____ - _____ Cell Phone (_____) _____ - _____ Work Phone (_____) _____ - _____

Birthdate _____ Employer _____

Dental Insurance Co. _____ Subscriber ID _____ Group # _____

Medical Insurance Co. _____ Subscriber ID _____ Group # _____

Person to Contact in Case of an Emergency _____ Relationship _____

Home Phone (____) _____ - _____ Cell Phone (____) _____ - _____ Work Phone (____) _____ - _____

FINANCIAL POLICY

INSURANCE

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

It is the responsibility of the insured/subscriber to check on their specific insurance benefits for all services provided and be aware that some or all of the procedures may not be covered.

Some insurance companies require a referral for optimal coverage. It is the responsibility of the insured/subscriber to acquire the proper referral.

I hereby authorize, assign, and transfer payment of services otherwise payable to me, directly to Oral and Maxillofacial Surgery Specialists, P.A. I authorize the release of x-rays and any information regarding examination or treatment. I agree to be responsible for all charges for services and materials not paid by my plan.

_____

PATIENT/SUBSCRIBER SIGNATURE DATE

FINANCIAL ARRANGEMENTS

PAYMENT IS EXPECTED AT THE TIME OF SERVICE BY

CASH CHECK CARE CREDIT

VISA MASTERCARD AMERICAN EXPRESS DISCOVER

Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area.

A deposit will be estimated, based on the insurance coverage and due at the time of surgery.

The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide our office with your insurance information. Any remaining balance after insurance has paid should be paid in full on the first statement. Monthly payments may be set up on a case by case basis with payments not exceeding three months after you have talked to your account representative.

In the event a collection agency is necessary, you will be responsible for all reasonable collection and attorney fees.

I have read the above statements and understand that I am financially responsible for the charges incurred, regardless of any insurance that I may have.

_____

RESPONSIBLE/BILLING PARTY SIGNATURE DATE