

# Oral and Maxillofacial Surgery Associates of Western New York, P.C.

PATIENT NAME: \_\_\_\_\_ MALE OR FEMALE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ PHONE#: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ PHONE#: \_\_\_\_\_

GENERAL DENTIST: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

MEDICAL PHYSICIAN: \_\_\_\_\_

PERSON RESPONSIBLE FOR ACCOUNT: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS IF DIFFERENT: \_\_\_\_\_

CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ WORK #: \_\_\_\_\_ EXT: \_\_\_\_\_

DENTAL INSURANCE (PRIMARY): \_\_\_\_\_

ADDRESS: \_\_\_\_\_

ID#: \_\_\_\_\_ GROUP#: \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

DENTAL INSURANCE  
(SECONDARY): \_\_\_\_\_

ADDRESS: \_\_\_\_\_

ID#: \_\_\_\_\_ GROUP#: \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

MEDICAL INSURANCE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

ID#: \_\_\_\_\_ GROUP#: \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

I understand that I am responsible for all patient charges and hereby authorize release of information and x-rays regarding the services rendered to the insurance company. We do accept Visa, Master Card, Discover, American Express, Care Credit, check and cash.

PLEASE NOTE: INSURANCE POLICIES ARE CONTRACTS BETWEEN THE PATIENT AND THE INSURANCE COMPANY. THE PATIENT IS ULTIMATELY RESPONSIBLE FOR FULL PAYMENT OF THIS ACCOUNT WITHIN 60 DAYS.

I understand I will be charged for any outside collection costs or attorney/court costs should this account be turned to an outside agency. 1.5% SERVICE FEE ACCRUED MONTHLY ON ALL BALANCES GREATER THAN 90 DAYS OLD.

I also authorize all insurance benefits to be paid directly to the doctor.

**X** \_\_\_\_\_

**SIGNATURE OF RESPONSIBLE PARTY**