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