ORAL AND MAXILLOFACIAL SURGERY

Mr./Mrs./Miss Name: Home Phone: ( )
Address: Work Phone: ( )
City: State: Zip:

Social Security #: Full Time Student: Yes No School:

Birth Date: Marital Status: M S W D Sep Are you currently serving in the military? Yes No

Employer: Position:
Address:
City: State: Zip:

Referred by: Phone #: ( )
Regular Dentist: Orthodontist: Periodontist:
Regular Physician: Phone #: ( )

It is customary to pay for services when rendered. My method of payment is: Cash Check Credit Card Medicare Insurance Other

Responsible Billing Party Information

Name: Home Phone: ( )
Address: Work Phone: ( )
City: State: Zip:
Social Security #: Date of Birth: Marital Status:
Employer: Address:
City: State: Zip:
Driver's License #:

Primary Insurance Information

Dental Insurance Co: Person Insured:
- Policy Number: Ins. Co. Phone Number: ( )
- Group Number: Date of Birth:
- MAIL CLAIMS TO: City: State: Zip:

Medical Insurance Co.: Person Insured:
- Ins. Co. Phone Number: Date of Birth:
- Policy Number: Group Number:
- MAIL CLAIMS TO: City: State: Zip:

Secondary Insurance Information

Dental Insurance Co.: Person Insured:
- Ins. Co. Phone Number: Date of Birth:
- Policy Number: Group Number:
- MAIL CLAIMS TO: City: State: Zip:

Medical Insurance Co.: Person Insured:
- Ins. Co. Number: Date of Birth:
- Policy Number: Group Number:
- MAIL CLAIMS TO: City: State: Zip:

In consideration for the professional services to be rendered, at my request by Gaetano G. Spinnato, D.M.D., M.D., I hereby understand and agree that I will be and remain personally responsible for services rendered. I hereby further understand/agree if I fail to pay an out-standing balance due as agreed upon or my account is delinquent and referred to a collection agency, company or individual for the purpose of collections, I will be and remain personally responsible for payment of any and all costs associated with and/or incurred by Dr. Spinnato with regard to such collection attempts. This will include but not be limited to attorney's fees and interest as provided by law. I also give permission to Dr. Spinnato to bill my credit card for any outstanding overdue balance. Finally, any overdue balance will incur a 1.5% interest charge per month if not paid one week after final notice of debt.

PATIENT (Parentif patient is a minor) DATE

Guardian DATE

In consideration of surgical treatment to be rendered to me/my dependents, I agree to sign over every dental/medical benefit payment issued to me for services performed by this office within 10 business days after receipt from a Dental Service Corporation, Medical Health Service Corporation or Dental Plan Organization, provided, however, if the amount owed to this office is less than the amount of the dental/ medical benefit payment, then only the balance owed shall be paid.

SIGNED (Insured Person) DATE

Guardian DATE