

Port Royal Oral and Facial Surgery

PATIENT INFORMATION

Today's Date: _____

Name: _____ Birth
date: _____ Age: _____ Sex: _____

Street Address: _____ City: _____ State: _____ Zip
Code: _____

Mailing Address: _____ City: _____ State: _____ Zip
Code: _____

Marital Status: _____ SSN#: _____

Home Phone: () _____ Cell Phone: ()

Occupation/Employer: _____ Work Phone: ()

INSURED AND RESPONSIBLE PARTY INFORMATION

****Insurance cards (both medical and dental) must be presented at check in if you choose for us to verify benefits and/or file your claims. It is the patient's responsibility to give us all current cards and necessary information. ****

Insured Name: _____ Relationship: _____

Birthdate: _____ Address: _____ Apt#: _____ S

SN#: _____ City: _____ State: _____

Zip Code: _____ Employer: _____

Work Phone: _____

****Please Note: We will be more than happy to assist you in filing your insurance claims. However, there may be a certain percentage to bring on the day of surgery and any unpaid claims by your insurance company past 60 days will be your immediate responsibility. Transfer of accounts to an outside collection agency for unpaid balances will result in a 30% interest fee added to your account.**

IN CASE OF EMERGENCY:

Contact:

Relationship:

Home Phone: ()

Work Phone: ()

Cell Phone: ()

Dentist Name:

Who referred you?

ASSIGNMENT AND RELEASE OF BENEFITS:

I hereby authorize payment directly to the doctors and/or Oral Surgeons for any & all services rendered. I fully understand that I will be financially responsible for any unpaid and/or non-covered services. I also give my authorization to the physician to release any information required in order to process the claim or for any other reason deemed necessary.

Signature:

Date:
