

MIDWEST



ORAL AND MAXILLOFACIAL SURGERY

Diplomate-American Board of Oral and Maxillofacial Surgery

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- PATIENT INFORMATION SHEET -

Date: \_\_\_\_\_

Title: (Mr., Mrs., Ms.) First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Sex:  Male  Female **DATE OF BIRTH:** \_\_\_\_\_ **AGE:** \_\_\_\_\_ **SOCIAL SECURITY NO.:** \_\_\_\_\_

Current Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ How Long? \_\_\_\_\_

Previous Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ How Long? \_\_\_\_\_

Home Tel.: (\_\_\_\_\_) \_\_\_\_\_ Bus. Tel.: (\_\_\_\_\_) \_\_\_\_\_

Name of nearest relative or friend: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
*(Not at the same address)*

Physician: \_\_\_\_\_ Dentist: \_\_\_\_\_ Referred By: \_\_\_\_\_

Who will be responsible for your account? Relation:  Self  Spouse  Mother  Father  \_\_\_\_\_

Name: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_ Home Tel.: (\_\_\_\_\_) \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ How Long? \_\_\_\_\_ Tel.: (\_\_\_\_\_) \_\_\_\_\_

Student: Full Time  Part Time  Not  School Name/Address \_\_\_\_\_

Married  Divorced  Legally Separated  Widow  Single  \_\_\_\_\_

Employed: Full Time  Part Time  Retired  Not  Do you belong to a Preferred Provider Organization?  Yes  No

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**PRIMARY INSURANCE COMPANY:** **INSURED PARTY: (WHO CARRIES INSURANCE, IF OTHER THAN PATIENT)**

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Address: \_\_\_\_\_ Relation to Insured:  Self  Spouse  Child  Other

Sex:  M  F Date of Birth: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ Street: \_\_\_\_\_

Will your plan cover today's treatment under:  Dental  Medical  Both City, State, Zip: \_\_\_\_\_

Group No.: \_\_\_\_\_ Group Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

S.S. No.: \_\_\_\_\_

**EMPLOYER INFORMATION: (OF INSURED PARTY)**

Name: \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Is this an Employer Health Insurance Plan?  Yes  No Employer ID No.: \_\_\_\_\_

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**SECONDARY INSURANCE COMPANY:** **INSURED PARTY: (WHO CARRIES INSURANCE, IF OTHER THAN PATIENT)**

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Address: \_\_\_\_\_ Relation to Insured:  Self  Spouse  Child  Other

Sex:  M  F Date of Birth: \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ Street: \_\_\_\_\_

Does your plan cover:  Dental  Medical  Both City, State, Zip: \_\_\_\_\_

Group No.: \_\_\_\_\_ Group Name: \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

S.S. No.: \_\_\_\_\_

**EMPLOYER INFORMATION:**

Name: \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Is this an Employer Health Insurance Plan?  Yes  No Employer ID No.: \_\_\_\_\_

## OUR FINANCIAL POLICY

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our "Financial Policy" is important to our professional relationship.

- All patients must complete our "Patient Information Form" before seeing the doctor.

I understand that charges for care provided to me will depend on what is wrong and what must be done to provide appropriate, quality dental care. If I received a charge estimate over the telephone, it was an attempt to provide me information I requested; but, because I had not been evaluated, such estimate is not a guaranteed price. In addition, all bills are subject to review by qualified billing and coding professionals, who may determine that additional charges or a refund may be due; thus, initial charges may not reflect my final bill.

**Charges of \$220.00 or less are expected to be paid on the day services are rendered; if over \$220.00, prior arrangements must be made.**

- We accept cash, checks, Visa, Mastercard and Discover.
- We offer financing through Care Credit and Personal Finance Co.
- There will be a **\$26.00 charge for returned checks.**

**How do you plan to pay for today's services?**     Cash     Check     Charge

## AGREEMENT TO PAY

I (we), undersigned, accept full financial responsibility for the treatment performed by this office. Insurance forms will be completed as a convenience to the patients; however, payment to Midwest Oral and Maxillofacial Surgery is expected at the time services are rendered, unless other arrangements are made. Should the services of an attorney be required for collection of this account, I (we) agree to pay reasonable attorney's fees, court costs, and other costs of collection.

In regard to treatment of minors, a divorced parent or legal guardian who accompanies a minor and gives permission for treatment is responsible for payment of the bill. This applies even if another parent/guardian has been determined by court settlement or judgement to be financially responsible. Both parents are jointly and severally responsible for payment of a minor's dental charges.

Signature of Patient or legal guardian  \_\_\_\_\_

Signature - Responsible Party \_\_\_\_\_

Signature - Responsible Party \_\_\_\_\_

## REGARDING INSURANCE

If you have insurance, we will help you receive maximum benefits.

**TOTAL BILL IS DUE IN 45 DAYS FROM DAY OF SERVICE EVEN IF INSURANCE HAS NOT RESPONDED.**

Most insurance companies set reimbursements that are at or below our fees after co-payments. However, you are still responsible for the full amount of the bill.

If your insurance company pays more than the balance due, we will send you a refund check immediately, if applicable. Insurance is a contract between you and your insurance company. **We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual & customary" charges, etc. other than to supply factual information as necessary.**

PATIENT SIGNATURE

\_\_\_\_\_ DATE \_\_\_\_\_

\*I understand the treatment planned for me and authorize the release of any information related to my insurance claim. I also authorize any group insurance benefits payable to me to be made directly to Midwest Oral and Maxillofacial Surgery.

ASSIGNMENT OF INSURED SIGNATURE

\_\_\_\_\_ DATE \_\_\_\_\_