PREMIER ORAL SURGERY
PATIENT REGISTRATION FORM
(Please Print)

Today's date:	Primary Care Provider:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Email:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

Cell phone no: ( )	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑Dr. _____ ❑ Insurance Plan ❑ Hospital
❑ Family ❑ Friend ❑ Dentist ❑ Orthodontist ❑ Other

Other family members seen here:

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

(Please Print)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Driver License no:	e-mail:	Cell phone no: ( )

Patient's relationship to subscriber: ❑ Self ❑Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Premier Oral Surgery or insurance company to release any information required to process my claims.

_____ _____
Patient/Guardian signature *Date*

PLEASE FILL OUT THE OTHER SIDE OF THIS FORM AS WELL.
Insurance Information is in the back of this form.

DENTAL INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance name:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Insurance Phone Number: ( )

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

MEDICAL INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance name:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Insurance Phone Number ( )

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

FINANCIAL POLICY

Full payment is due at the time of service. If you have insurance deductible and co-payments, they are due at the time of service. Patient is responsible for all fees incurred in the office. Any service not covered by insurance will be at the responsibility of the patient. Most insurance companies make payment within 4-6 weeks. There will be a 1% monthly interest charge (12% per annum) applied monthly to any account balance exceeding 60 days, regardless of insurance status. If your account becomes delinquent an it is referred to a collection agency.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I also authorize Premier Oral Surgery or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*