Please print clearly. Please complete all information so that your claim can be processed quickly and efficiently. Thank you!

PATIENT INFORMATION

First **M.** **Last** **Nickname**

Mailing Address: **APT #:**

City: **State:** **Zip:**

Home Phone #: **Cell Phone #:** **Work #:**

Date of Birth: **SSN:** **Sex: Male / Female**

Marital Status: S M W D **Email Address:**

Employer: **Employer's Number:**

If Student, School Name: **Full / Part Time**

*****Emergency Contact Not Living with Patient:*** ***Phone:***

RESPONSIBLE PARTY OR PARENT INFORMATION

if patient is under the age of 18 please fill out

Name of Person Responsible for this Account: **Relation to Patient:**

Mailing Address: **APT #:**

City: **State:** **Zip:**

Phone #: **SSN:** **Date of Birth:**

Employer: **Work Phone #:**

Employer's Address:

How did you hear about us? *Dental Provider* *Ad* *Friend or Patient* *Social Media* *Other*

Referring Doctor/Dental provider: **Who Should Receive Report?**

Primary Care Doctor: **Phone #:**

If this appointment is due to an accident please list the nature of accident and date:

DENTAL INSURANCE INFORMATION

Primary Ins. Company: **Phone #:**

Claims Address:

Policy or ID #: **Group#:**

Policy Holder's Name (if different from patient): **Policy Holder's SSN:**

Policy Holder's DOB: **Sex: Male / Female** **Patient's Relationship to Policy Holder: Spouse Self Dependent/Child**

Policy Holder's Address:

Policy Holder's Employer: **Phone:**

Please Complete and Sign Reverse Side

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If the patient is covered by another insurance policy, please complete the following information for coordination of benefits. This information will enable your insurance company to process your claim more quickly. Thank you.

Secondary Ins. Company:		**Phone #:**
Claims Address:		
Policy or ID #:		**Group #:**
Policy Holder's Name (if different from patient):		**Policy Holder's SSN:**
Policy Holder's DOB:	**Sex: Male / Female**	**Patient's Relationship to Policy Holder:** **Spouse Self Dependent/Child**
Policy Holder's Address:		
Policy Holder's Employer:		**Phone:**

MEDICAL INSURANCE INFORMATION		
Primary Ins. Company:		**Phone #:**
Claims Address:		
Policy or ID #:		**Group #:**
Policy Holder's Name (if different from patient):		**Policy Holder's SSN:**
Policy Holder's DOB:	**Sex: Male / Female**	**Patient's Relationship to Policy Holder:** **Spouse Self Dependent/Child**
Policy Holder's Address:		
Policy Holder's Employer:		**Phone:**

Secondary Ins. Company:		**Phone #:**
Claims Address:		
Policy or ID #:		**Group #:**
Policy Holder's Name (if different from patient):		**Policy Holder's SSN:**
Policy Holder's DOB:	**Sex: Male / Female**	**Patient's Relationship to Policy Holder:** **Spouse Self Dependent/Child**
Policy Holder's Address:		
Policy Holder's Employer:		**Phone:**

I have completed this form fully and certify that I am the patient or duly authorized general agent of the patient. As the responsible party, I agree to pay all charges incurred by myself and members of my family to Oral Surgery UAB Medicine Inverness. In the event of default in payment, I agree to pay a late charge equal to 30% per annum of any unpaid balance and to pay all cost of collection, including a reasonable attorney's fee. I understand that even though I may have some type on insurance, I am responsible for all payment of services.

Preferred Method of Payment: ___Check ___Cash ___Visa/MasterCard___ Discover ___ American Express ___CareCredit

Signature of Responsible Party: ___________________________________Date: _____________________

Signature of Patient OR Parent/ Guardian if Minor: ___________________________ Date: ___________