San Benito Oral and Maxillofacial Surgery a Dental Practice - Dr. R.L. McBride - Dr. J.M. Wittenberg

PATIENT INFORMATION

Title: (Mr., Mrs., Ms., Miss) First Name _____ Middle Initial _____ Last Name _____

Sex: ☐ Male ☐ Female Date of Birth _____ Age _____ Social Security # _____

MAILING ADDRESS Email: _____

Street: _____ City: _____ State: _____ Zip: _____

Home Tel: _____ Cell Tel: _____ Buss.Tel: _____

General Dentist: _____ Referred By: _____ Physician: _____

Student: Full Time ☐ Part Time ☐ Not ☐ School Name/Address: _____

Married ☐ Divorced ☐ Legally Separated ☐ Widow ☐ Single ☐ Spouse Name: _____

Employed: Full Time ☐ Part Time ☐ Retired ☐ Not ☐ Employer: _____ Tel. # (_____) _____

Who will be responsible for your account? Relation: Self ☐ Spouse ☐ Mother ☐ Father ☐ _____ DOB: _____

Name: _____ Social Security #: _____ Home Tel # (_____) _____

Street: _____ City: _____ State: _____ Zip: _____

Employer: _____ Tel. # (_____) _____

Name & Address of Nearest Relative Not Living With Responsible Party: Name: _____ Tel. # (_____) _____

Street: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE COMPANY

Ins. Co. Name: _____

Address _____

Phone #: _____

Employer: _____

Bus. Phone #: _____

Employee Name: _____

Employee Date of Birth: _____

Group #: _____ S.S. #: _____

ID# _____

PRIMARY MEDICAL INSURANCE COMPANY

Ins. Co. Name: _____

Address _____

Phone #: _____

Employer: _____

Bus. Phone #: _____

Employee Name: _____

Employee Date of Birth: _____

Group #: _____ S.S. #: _____

ID# _____

SECONDARY DENTAL INSURANCE COMPANY

Ins. Co. Name: _____

Address _____

Phone #: _____

Employer: _____

Bus. Phone #: _____

Employee Name: _____

Employee Date of Birth: _____

Group #: _____ S.S. #: _____

ID# _____

SECONDARY MEDICAL INSURANCE COMPANY

Ins. Co. Name: _____

Address _____

Phone #: _____

Employer: _____

Bus. Phone #: _____

Employee Name: _____

Employee Date of Birth: _____

Group #: _____ S.S. #: _____

ID# _____

FEES AND PAYMENTS

TO ALL OUR PATIENTS:

We make every effort to keep down the cost of your oral and maxillofacial, facial plastic surgical care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information in this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay percentage of the charge. It is your responsibility to pay any deductible amount co-insurance or any other balance not paid for by your insurance company and/or including attorney fees or collection fees incurred to collect this debt.

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Payment responsibility today will be taken care of by: ☐ Cash ☐ Check ☐ Credit Card

_____ _____ _____

Patient Signature or Guardian (if under 18 yrs. of age) Driver's License # Date

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