

PATIENT INFORMATION

Name _____ Date _____
 SS# _____ Age _____ Date of Birth _____ Sex _____ Marital Status _____
 Address _____ City _____ State _____ Zip _____
 Where Employed _____ Position _____
 Business Address _____ City _____ State _____ Zip _____
 Are you a student? Yes No School _____ City _____ Full Time Part Time
 Home Phone _____ Business Phone _____ Cell Phone _____
 Notify in case of emergency _____ Phone _____
 Referred by _____ Medical Doctor _____
 Dentist _____ Orthodontist _____
 Method of payment today: Cash Check MC/Visa Driver's License # _____

Person Responsible for account (if different than above)

Name _____ Relationship _____
 Address _____ City _____ State _____ Zip _____
 Where Employed _____ Position _____
 Business Address _____ City _____ State _____ Zip _____
 Home Phone _____ Business Phone _____

INSURANCE INFORMATION

*The following information is necessary if we will be filing insurance for your re-imbusement. We **do not** normally accept insurance as a form of payment unless specific arrangements have been made.*

Insurance Company (Medical) _____ Policy # _____
 (Dental) _____ Policy # _____

Address where claim is to be mailed _____

Policyholder's Name _____ D.O.B. _____ SS# _____

Relationship to patient _____ Group or individual policy _____

Employer's Name _____ Is group policy through employer? _____

Address _____

Secondary Insurance Information (if any)

Insurance Company (Medical) _____ Policy # _____
 (Dental) _____ Policy # _____

Address where claim is to be mailed _____

Policyholder's Name _____ D.O.B. _____ SS# _____

Relationship to patient _____ Group or individual policy _____

Employer's Name _____ Is group policy through employer? _____

Address _____

CONSENT FOR EXAMINATION & X-RAYS / INSURANCE AUTHORIZATION & ASSIGNMENT

I authorize Dr. Edmund I. Parnes to perform an oral and maxillofacial examination upon _____, for the purpose of diagnosis and treatment planning. I certify that the medical history I have given is correct. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize release of any information acquired in the course of my examination or treatment. I hereby assign to the physician all insurance payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. In the event that this account is placed in the hands of a collection agency or attorney, I agree to pay all collection costs and fees.

DATE _____ SIGNATURE _____

WITNESS _____ RELATIONSHIP TO PATIENT _____