Colorado Oral Surgery Center – PATIENT INFORMATION FORM

Date: __________________

①

Title: (Mr., Mrs., Ms.) First Name __________________ Middle Initial: ____ Last Name: __________________

Sex: ☐ Male ☐ Female Date of Birth : __________________ Age: ____ Social Security No.: __________________

Address: __________________ City/State/Zip: __________________

Home Tel.: (______) __________________ Cell Tel.: __________________

Employer: __________________ Work Tel.: (______) __________________ Ext. __________________

Physician: __________________ Physician's Tel.: __________________

Dentist: __________________ Dentist Tel.: (______) __________________

Student: Full Time ☐ Part Time ☐ Non Student ☐ School/City: __________________

Married ☐ Divorced ☐ Legally Separated ☐ Widow ☐ Single ☐ Employed: Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐

Referred By: __________________

②

PRIMARY INSURANCE COMPANY:

Name: __________________

Address: __________________

____

Phone: (______) __________________

Does your plan cover: ☐ Dental ☐ Medical ☐ Both

Group No.: __________________ Group Name __________________

Plan Name & No.: __________________

SUBSCRIBER:

Name: __________________

Date of Birth: __________________

Street: __________________

City, State, Zip: __________________

Phone: (______) __________________

Social Security No.: __________________

Patient relation to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

EMPLOYER INFORMATION:

Name: __________________

Street: __________________ City: __________________ State: ______ Zip __________________

Is this an Employer Health Insurance Plan? ☐ Yes ☐ No Employer ID No.: __________________

③

SECONDARY INSURANCE COMPANY:

Name: __________________

Address: __________________

____

Phone: (______) __________________

Does your plan cover: ☐ Dental ☐ Medical ☐ Both

Group No.: __________________ Group Name __________________

Plan Name & No.: __________________

SUBSCRIBER:

Name: __________________

Date of Birth: __________________

Street: __________________

City, State, Zip: __________________

Phone: (______) __________________

Social Security No.: __________________

Patient relation to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

EMPLOYER INFORMATION:

Name: __________________

Street: __________________ City: __________________ State: ______ Zip __________________

Is this an Employer Health Insurance Plan? ☐ Yes ☐ No Employer ID No.: __________________

④

FEES AND PAYMENTS:

We make every effort to keep down the cost of your oral surgery care. 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 at the top of the form.

Please remember that insurance is considered a method of reimbursing the patient for fees to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a 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.

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

In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection cost and reasonable attorney's fees incurred to effect collection of this account or future outstanding accounts.

Signature: __________________