HERMITAGE
ORAL & MAXILLOFACIAL SURGERY

PATIENT INFORMATION SHEET
(Please Print Clearly)

Date: _____ Preferred pharmacy: _____

Patient Information

Patient's full name: _____
(First) (Middle) (Last)

Address: _____
(Street #) (Street) (City) (State/Zip)

Age:_____ DOB: _____ **Male** or **Female** or **Other**

Social Security #: _____ Patient's Dentist: _____

We cannot guarantee an unconfirmed appointment. There is a surgery no show fee of $60.00.

Best contact number: _____ Can we leave a message? Y N Can we text? Y N

Alternative contact number: _____

Employer: _____ Employer phone number: _____

Emergency Contact Information (Spouse, Parent/Guardian)

Name: _____ Address: _____

Phone: _____ Relation to Patient: _____

Insured Person's Information (If different than the patient information)

Insured's Name: _____ Relation to Patient: _____

Insured's DOB: _____ Insured's Social Security Number: _____

Insured's Employer: _____ Business Phone: _____

Person Responsible for this Account Patient or Other? If other, please fill out below:

Name: _____ Relation to Patient: _____

Address: _____

Notice of HIPAA Privacy Practices

We have a framed copy of the HIPAA Privacy Practices in the waiting room. We can provide a copy for you if you like.

I have been notified of the privacy practices of this office:

_____ _____
Printed Name Signature (if under 18, parent/guardian signature)

Please list anyone with whom we may discuss your account:

(i.e., spouse, parent, or friend)_____

(Continued on other side)

PAYMENT INFORMATION

Thank you for allowing us the opportunity to treat you! Our goal is to serve your oral surgery needs in a friendly and caring atmosphere. We appreciate your repeat business and all your referrals of friends and family. We would like to disclose to you our office financial policies.

WHETHER YOU HAVE INSURANCE OR NOT

Each patient, or if a minor, each patient's parent or legal guardian, is responsible for any charges on his or her account. In the event of default of payment, you will be responsible for any collection costs, court costs, and attorney fees that we incur to collect on your account. If there is a returned check, there will be a return check fee added to your account.

IF YOU DO NOT HAVE INSURANCE

Payment is due in full when services are provided. We accept cash, checks, Care Credit, Mastercard, Visa, American Express, and Discover credit cards. If for some reason we do bill you (i.e. returned check), your account is due in full. If after 30 days of being billed your account is not paid in full, a $5.00 service charge will be added to your account each month until your balance is paid in full.

IF YOU DO HAVE INSURANCE

We do accept insurance assignment, provided we are given complete and accurate information about your insurance coverage. It is your responsibility to see if we are in network with your medical and/or dental insurance. We accept and file your insurance as a courtesy to you. We will make every effort to verify your benefits. If, for some reason, we are unable to contact your insurance company or they will not disclose your benefits or fee schedules, payment is due in full when services are rendered. Some insurance companies will not pay on general anesthesia, unless it is a medical necessity and not due to patient comfort. Sometimes we do not know how they will pay on this service until actual payment is made to us by your insurance company. If this happens, you will be responsible for this expense. If we do not receive an insurance payment within 90 days of filing, or we do receive a payment, but it is less than what we estimated, your balance is due in full. If we do not receive payment in full after 30 days of your being billed, a $5.00 service charge will be added to your account each month, until we receive payment in full on your account.

We are not a participating provider in all Medicare programs. Please be aware that your Medicare coverage may not apply to services provided by this office.

PAYMENT AGREEMENT WITH OR WITHOUT INSURANCE

I understand the payment information as stated above. I also understand that my insurance is a contract between myself and the insurance carrier and not between my doctor / Hermitage Oral Surgery and the insurance company, and that I am still responsible for all fees.

Signature:_____ Date: _____