PATIENT REGISTRATION AND INSURANCE INFORMATION

Welcome to our practice. We are delighted that you have chosen us for your oral surgery needs. Please provide us with the following information to better serve you. Thank you.

Date:_____ **Title (Please circle one): Mr. Mrs. Ms. Miss**

Patient's Full Name: _____

Patient's Address:_____
(Street) (City) (State) (Zip)

Home Phone Number:_____ **Business Number/Ext.:**_____

Sex:_____ **Birth Date:**_____ **Age:**_____ **Soc. Sec.#**_____

Cell Phone Number:_____ **Spouse's Name:**_____

Patient's Employer:_____ **Full Time?**_____

Referred to us by:_____ **Your Dentist is:**_____

Your Medical Doctor is:_____ **Have you or any other family member**

been to see Dr. Williams before?_____

Your orthodontist is:_____

Emergency Contact:_____ **Phone #:**_____

NOTE: We may attempt to contact you at your business number, cell phone number and/or your home phone number. If you personally are unavailable, we will leave our name and return phone number with a brief message.

Who will be responsible for your account? _____**Self** _____**Parent or Legal Guardian**
(If self, please skip this section.)

Name of Parent or Legal Guardian:_____

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

Home Phone #:_____ **Soc. Sec.#**_____

Employer:_____ **Business #/Ext.:**_____

If you are covered by any medical or dental insurance plans, please provide us with the following information. We will need to copy your insurance cards as well. If you do not have any medical or dental insurance, please write "none" below and skip to the next section. Thank you.

(complete other side)

DENTAL INSURANCE:

Name of Insured/Policy Holder:_____

Insured's Relationship to Patient: ___Self ___Spouse ___Parent ___Step-Parent ___Other

Insured/Policy Holder Birth Date:_____ **Insured/Policy Holder Soc. Sec.#**_____

Name of Insurance Company:_____**Phone#:**_____

Address For Claim Submission:_____

Employer:_____ **Group #**_____

Employer Phone Number:_____ **Is treatment due to an accident**

or injury?_____ **If yes, please alert the receptionist immediately.**

MEDICAL INSURANCE:

Name of Insured/Policy Holder:_____

Insured's Relationship to Patient: ___Self ___Spouse ___Parent ___Step-Parent ___Other

Insured/Policy Holder Birth Date:_____ **Insured/Policy Holder Soc. Sec.#**_____

Name of Insurance Company:_____**Phone #:**_____

Address to which we send claims:_____

Employer:_____**Phone #:**_____

FOR MEDICARE PATIENTS ONLY:

I understand that Dr. Christopher J. Williams is not a participating provider for Medicare and is not responsible for filing of claims on my behalf. Any reimbursement for covered procedures that may be performed by Dr. Williams will be sent directly to me upon my filing of the claim as per Medicare regulations.

_____**Patient's Signature**

ALL PATIENTS:

I acknowledge that the above information is correct and I agree to notify Dr. Williams of any changes that may occur. I agree to pay any charges incurred and if I have insurance, I agree to pay any deductible, co-payment or other amounts that may not be covered by my insurance plan. My signature below serves as authorization to Dr. Williams to release any medical/dental records as required by law and HIPPA regulations for appropriate care with other providers; to process any insurance claims; and to receive payment/insurance benefits otherwise payable to the insured. I understand that there could be late charges and/or collections fees assigned to me as a result of non-payment of fees.

_____**Signature of Responsible Party** _____**Date**