Welcome To Our Practice
StoneCrest Oral & Maxillofacial Surgery

Date:_____ **Patient Name:**_____

Circle Appropriate: Minor Single Married

SS#_____ **Male** **Female** **Birthdate:**_____

Employer : _____ **Occupation**_____

Home Phone# _____ **Cell#**_____ **E-Mail Address**_____

Address_____**Apt#**_____

City_____ **State**_____ **Zip** _____

Whom may we thank for referring you? _____

□ **NO INSURANCE COVERAGE -** ***PAYMENT IS DUE AT THE TIME OF SERVICE***

Insurance Information

Name of Insured_____ **Relationship to patient**_____

Birth date_____ **SS#**_____ **Employer:** _____ Work #_____

Address_____**City**_____**State**_____**Zip**_____

Insurance Company Name _____ Group#_____ ID#_____

Do you have any additional insurance Yes No If yes, completes the following:

Name of Insured_____ Relationship to patient_____

Birthdate_____ SS#_____

Employer :_____ Work # _____

Insurance Company Name_____ Group#_____ ID#_____

Authorization & Release

I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. We require your portion of payment at the time services are performed. Stone crest Oral Surgery reserves the right to refer unpaid past due balances to third parties for collection. In the event that any past due balance is placed with a third party, I agree to pay any costs of such collection including agency fees, legal/ attorney fees and court costs.

_____ _____ _____ _____

Signature of patient (or parent if minor) Date Signature of authorized representative of Stone crest OMS, Inc.