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 Primary

Name of Insured_____**Relationship to patient**_____

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

Insurance Company Name _____Group#_____ ID#_____

Secondary Insurance Policy **Yes** **No** **If yes, complete 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. I understand that Stonecrest Oral Surgery calls to check on Insurance benefits**, but it does not guarantee authorization of payment for any service. We require your portion of payment at the time services are performed**. Stonecrest Oral Surgery reserves the right to refer unpaid past due balances to third parties for collection. Your account will be subject to a 8% interest for all past due balances. 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.