

**PLEASE COMPLETE
BOTH SIDES IN INK!**

NORMAN V. PALM, D.D.S. • RICHARD W. PANEK, D.D.S. • JULIE B. BILLUPS, D.D.S.

Oral and Maxillofacial Surgery

PATIENT INFORMATION SHEET

Date _____

First Name _____ Middle Initial _____ Last Name _____

Preferred Name _____ Male/Female _____ Date of Birth _____ Age _____

SS# _____ Street Address _____

City _____ State _____ Zip Code _____

Home Tel# (_____) _____ - _____ Patient's Employer _____

Employer's Address _____ City _____ State _____

Employer's Tel# (_____) _____ - _____ Patient's Marital Status _____

Spouse's Name _____ Spouse's Employer _____ SS# _____

Address _____ City _____ State _____

Physician _____ Dentist _____ Referred by _____

Are you a student? yes no Where? _____ part time full time

Is there someone else who is responsible for your account? yes no

Name _____ SS# _____

INSURANCE INFORMATION: Primary (1st to be billed)

Employer _____

Name of Insurance _____

Address _____

Phone (_____) _____ - _____

Dental Medical Both

Group # _____

Employee Name _____

Employee Birthdate _____

Employee SS# _____

Employee I.D. # _____

The employee is: Yourself Spouse Parent

Other Explain _____

INSURANCE INFORMATION: Secondary (2nd to be billed)

Employer _____

Name of Insurance _____

Address _____

Phone (_____) _____ - _____

Dental Medical Both

Group # _____

Employee Name _____

Employee Birthdate _____

Employee SS# _____

Employee I.D. # _____

The employee is: Yourself Spouse Parent

Other Explain _____

FINANCIAL POLICY: Payment is due in full on the date of service. We accept cash, checks, VISA, MasterCard, and Discover/Novus and alternative financing through Carecredit, a healthcare credit card.

INSURANCE POLICY: We will submit insurance claims for you. An INITIAL payment is due on the date of service.

FINANCE CHARGE: After 60 days any balance unpaid by your insurance is considered past due and is due in full by you. A finance charge of 1 1/2% is added monthly to your past due account. This represents an annual percentage rate of 18%.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment directly to Palm & Panek DDS PC of any and all medical and or dental insurance payments. This assignment remains in effect until revoked by me in writing.

RELEASE: I authorize Palm & Panek DDS PC to release any information we deem necessary regarding my treatment to my insurance company, dentist, primary care physician, parent, child or spouse.

I HAVE READ, UNDERSTAND AND AGREE TO ALL OF THE ABOVE.

SIGNED _____ Date _____
Patient

CO-GUARANTOR _____ Date _____