AMES ORAL SURGEONS PC
MARSHALLTOWN ORAL SURGEONS PC

GENERAL PATIENT INFORMATION

Date: _____

Patient Name: Last Name: _____ First Name: _____

Date of Birth: _____ Age: _____ Sex: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____ Primary Ph#: _____

Secondary Ph#: _____ Email: _____

*Soc. Sec. #: _____ Driver's License State and #: _____

Employer: _____ Work Ph#: _____

Employer Address: _____

Referring Doctor: _____

Pharmacy you use: _____ Location/Cross Streets: _____

***Payment in full by cash, credit card or money order will be accepted if you do not wish to provide your SS#**

IF PATIENT IS A MINOR:

If the patient is under 18, the person accompanying him/her is responsible for the account. Please fill in the following information for the person who is in the office with the minor patient.

Parent/Guardian Name: _____ Relationship to Patient: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Ph#: _____ Alt. Ph#: _____ Email: _____

*Soc. Sec. #: _____ Driver's License State and #: _____

Employer: _____ Work Ph#: _____

Employer Address: _____

***Payment in full by cash, credit card or money order will be accepted if you do not wish to provide your SS#**

EMERGENCY CONTACT:

Name: _____ Primary Ph#: _____

Relationship to Patient: _____

PRIMARY INSURANCE INFORMATION:

Dental Insurance Company: _____ Phone#: _____

Address: _____

Insured Name: _____ SS or ID#: _____ Date of Birth: _____

Employer: _____ Group ID#: _____

Medical Insurance Company: _____ Phone#: _____

Address: _____

Insured Name: _____ SS or ID#: _____ Date of Birth: _____

Employer: _____ Group ID#: _____

SECONDARY INSURANCE INFORMATION:

Dental Insurance Company: _____ Phone#: _____

Address: _____

Insured Name: _____ SS or ID#: _____ Date of Birth: _____

Employer: _____ Group ID#: _____

Medical Insurance Company: _____ Phone#: _____

Address: _____

Insured Name: _____ SS or ID#: _____ Date of Birth: _____

Employer: _____ Group ID#: _____

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FINANCIAL POLICY

Payment is expected at the time services are rendered. As a courtesy to you we will file your insurance claim if you provide us with all the accurate and required information. Please remember that insurance companies rarely reimburse the full amount of surgical fees. We recommend you contact your insurance company regarding any questions about your benefits. We do not quote any insurance benefits. Please remember that any fees quoted by your insurance companies are an estimate only. If the procedure proves to be more complex than anticipated, the fees will be adjusted accordingly. It is your responsibility to pay any deductible amount, co-insurance, or any other balance denied by or not paid by your insurance company.

If the account is assigned to an attorney or outside agency for collection, you will be responsible for any collection costs / attorney fees.

For you convenience, we offer the following payment options:

CASH, PERSONAL CHECKS, CREDIT CARDS: MASTERCARD, VISA, DISCOVER, and AMERICAN EXPRESS, and CARE CREDIT.

A $25.00 fee will be added to your account for any returned checks.

I authorize the release of any information necessary to process the insurance claim(s). I authorize the use of this signature on all of my insurance claims, manual or electronic. I further authorize benefits payable to AMES ORAL SURGEONS, P.C.

I have read the office financial policy and I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature_____ Date_____

Ames Oral Surgeons, P.C. and Marshalltown Oral Surgeons, P.C. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-515-232-6830.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-515-232-6830。