THE Maxillofacial Surgery CENTER

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NEW PATIENT INFORMATION:

First Name: _____ MI: _____ Last Name: _____ Gender: ☐M / F☐
Nickname: _____ Date of Birth: _____/_____/_____ Age: _____
Social Security #: _____-_____-_____ Email Address: _____
Mailing Address: _____
City: _____ State:_____ Zip code: _____
Home phone: ( ) _____ Work/Cell phone: ( ) _____
Employer: _____ Employer Phone: ( )_____
Employer Address: _____
Spouse's Name: _____Spouse's Social Security #: _____-___-_____

Visit Information:
Who can we thank for referring you to our office? _____
General Dentist's name: _____
Have you, a family member, or friend ever been treated in this office before? ☐Yes ☐No
If so, please indicate your relative's/friend's name _____

PERSON RESPONSIBLE FOR PAYMENT **** This section must be completed if patient is a minor***
Same as patient? ☐ yes ☐ no *If other than patient, please complete information below
First Name: _____ MI: _____ Last Name: _____ Gender: ☐M / F☐
Relationship to Patient: _____ Date of Birth:_____/_____/_____ SSN #: _____-_____-_____
Mailing Address: _____
City: _____ State:_____ Zip code: _____
Home phone: ( ) _____ Work/Cell phone: ( ) _____
Employer: _____ Employer Phone: ( )_____
Employer Address: _____
City State

IF MARRIED:
Spouse First & Last Name: _____ Date of Birth: _____/_____/_____
Spouse Employer: _____ Spouse SSN: _____-_____-_____
Employer Address: _____ Spouse Cell # ( )_____

EMERGENCY CONTACT INFORMATION * Please include someone other than spouse
Full Name: _____ Relationship to Patient:_____
Home phone: ( ) _____ Work/Cell phone: ( ) _____

INSURANCE INFORMATION
Is the patient covered by Medicare or Medicare replacement plan? ☐Yes ☐No

Primary Dental Insurance:
Insurance company's name: _____
Phone: ( ) _____ Policy ID# _____ Group or Plan #_____
Policy holder's name: _____ Relationship to patient: _____
Date of birth: _____/_____/_____ Social Security Number: _____-_____-_____

Secondary Dental Insurance:
Insurance company's name: _____
Phone: ( ) _____ Policy ID# _____ Group or Plan #_____
Policy holder's name: _____ Relationship to patient: _____
Date of birth: _____/_____/_____ Social Security Number: _____-_____-_____

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Medical Insurance:
Insurance company's name: _____
Phone: ( ) _____ Policy ID# _____ Group or Plan #_____
Policy holder's name: _____ Relationship to patient: _____
Date of birth: _____/_____/_____ Social Security Number: _____-_____-_____

AHCCCS Dental Insurance Information:
Insurance Plan name: _____ AHCCCS ID#: A_____

FINANCIAL POLICY

Thank you for choosing The Maxillofacial Surgery Center for your oral and/or maxillofacial surgery needs. Please review the policies below which govern the payment terms for any treatment you receive.

PLEASE INITIAL EACH SECTION BELOW AND SIGN AT THE BOTTOM.

_____ **PAYMENT OPTIONS**
I understand that payment of my bill is part of my treatment and that I am responsible for all charges incurred. My estimated portion of any fees is due in full at the time services are performed. Dr. Wilson's staff will inform me of the treatment plan and associated fees, discuss the financial options and method of payment. The Maxillofacial Surgery Center accepts cash, Visa, MasterCard, American Express, and Care Credit. Checks are not accepted.

_____ **DENTAL INSURANCE**
I agree to be responsible for any co-payments, deductibles, co-insurance, and all charges for services and materials not paid by my insurance plan. *It is my responsibility to know what services are covered and any limitations of my particular policy. It is also my responsibility to know if Dr. Spencer Wilson is an "in-network" provider prior to obtaining services*. In the event my insurance changes or is terminated, it is my responsibility to provide the office of Dr. Wilson with the new information.

I understand that The Maxillofacial Surgery Center bills participating insurance companies as a *courtesy* to its patients. Any estimated insurance coverage given to patients by The Maxillofacial Surgery Center is not a guarantee of actual insurance coverage. Verification of benefits is not a guarantee that my insurance company will make payment and, rather, insurance benefits are determined by my insurance company when the claim is received. I am responsible for any and all allowable charges which remain after my insurance has paid its portion.
I consent to the use and disclosure of my protected health information to carry out payment activities in connection with this claim. I also hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Dr. Spencer Wilson at The Maxillofacial Surgery Center.

_____ **DELINQUENT ACCOUNTS**
Accounts will be considered delinquent if unpaid after 60 days from the date of service. Delinquent accounts will be charged interest at the rate of 1.5% per month (18% per annum) or the maximum amount allowable at law, whichever is greater, as well as a $50.00 collection fee. If my account becomes delinquent, The Maxillofacial Surgery Center reserves its right to pursue collection through any legal means. I understand that patients are responsible for all costs associated with pursuing collection, including court and attorneys' fees, and the $50.00 collection fee.

I have read, understand, and agree to abide by the Financial Policy of The Maxillofacial Surgery Center.

*Is there anyone you would like to list as someone that can receive your personal or financial information other than your Doctors? (Parent, spouse, etc.) If so, please list: _____

Signature of Patient: _____
Signature of guardian if patient is a minor: _____
Printed Name of Guardian: _____ Date: _____

I agree that the information stated above is true to the best of my knowledge and will be held in strict confidence by The Maxillofacial Surgery Center. I am aware that it is my responsibility to notify this office of any changes in information. I hereby authorize and direct payment of benefits otherwise payable to me, to be paid directly to this office.