STEPHEN E. NEEDLE, D.D.S. ORAL AND MAXILLOFACIAL SURGERY

PATIENT INFORMATION

Today's Date_____ Referred By_____

Patient Name_____//_____
First Name M.I. Last Name Name you prefer to be called

Age_____ Date of Birth_____ Gender: M F Marital Status: S M DP D W

Social Security #_____ Employer _____

Driver's Lic. #_____ Occupation_____

Home Address_____ Work Address_____

City/State/Zip_____ City/State/Zip_____

Home Phone(_____)_____ Work Phone (_____)_____

Cell Phone (_____)_____ Email_____

Dentist_____ Physician_____

Dentist Phone(_____)_____ Physician Phone(_____)_____

Emergency Contact_____(_____)_____
Name Phone Relationship

If you are married, please complete the spouse section below.
If you are a minor or not the insured party, please complete the Responsible Party, Father, and Mother sections below.

Spouse Information if Married	**Responsible Party Information**
Name_____	Name_____
Date of Birth_____	Relationship to Patient_____
Social Security # _____	Social Security # _____
Driver's License #_____	Driver's License #_____
Employer_____	Employer_____
Occupation_____	Occupation_____
Employer Address_____	Employer Address_____
City/State/Zip_____	City/State/Zip_____
Home Phone(_____)_____	Home Phone(_____)_____
Work Phone (_____)_____	Work Phone (_____)_____
Cell Phone (_____)_____	Cell Phone (_____)_____
Email_____	Email_____

Father Information	**Mother Information**
Name_____	Name_____
Employer_____	Employer_____
Occupation_____	Occupation_____
Employer Address_____	Employer Address_____
City/State/Zip_____	City/State/Zip_____
Home Phone(_____)_____	Home Phone(_____)_____
Work Phone (_____)_____	Work Phone (_____)_____
Cell Phone (_____)_____	Cell Phone (_____)_____
Email_____	Email_____

Are you a college student? _____ No _____Yes _____Full Time _____Part Time

College Name and Location_____

Method of Payment (check all applicable) ____Cash ____ Credit Card _____ I would like to apply for payment plan

PRIMARY DENTAL INSURANCE	SECONDARY DENTAL INSURANCE
Company Name_____	Company Name_____
Address_____	Address_____
Group #_____	Group #_____
Policy #_____	Policy #_____
Phone # (_____)_____	Phone # (_____)_____
Name of Insured_____	Name of Insured_____
Relationship to Patient_____	Relationship to Patient_____
Member or SS#_____DOB_____	Member or SS#_____DOB_____

PRIMARY HEALTH INSURANCE	SECONDARY HEALTH INSURANCE
Company Name_____	Company Name_____
Address_____	Address_____
Group #_____	Group #_____
Policy #_____	Policy #_____
Phone #(_____)_____	Phone # (_____)_____
Name of Insured_____	Name of Insured_____
Relationship to Patient_____	Relationship to Patient_____
Member or SS#_____DOB_____	Member or SS#_____DOB_____

FEES AND PAYMENTS

We make every effort to keep down the cost of your oral surgical care. You can help by paying upon completion of each visit. Our policy requires payment in full for all services rendered at the time of the visit. Other arrangements can be made depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you. If you have any dental and/or medical insurance, we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please know that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay a fixed allowance for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. At times your insurance company may advise that they will pay for certain services, but the final determination of coverage with be as set forth on the Explanation of Benefits received by you from your insurance company. Any overpayment will be reimbursed, and any underpayment is the patient's responsibility to pay to this office.

A 1.5% finance charge, 18% annually, will be added to any balance over 90 days. If the account is not paid in full at the time of services and no financial arrangements have been made, you will be responsible for all collection costs, attorney fees and court costs, interest charges, and any other expenses incurred in collecting your account.

I certify that I have read and understand the above and agree to the terms. I authorize the release of information necessary to process my claim.

_____ _____

Signature Date

PATIENT ACKNOWLEGMENTS

I acknowledge that I have been given a copy of the Notice of Privacy Practices to review. (HIPAA)

I certify that the information I provided in the Patient Information Form is true and correct. I will not hold Dr. Stephen Needle or his staff responsible for any errors or omissions in the furnishing of information on this form.

_____ _____

Signature Date