Welcome to Chatham Oral & Maxillofacial Surgery, P. C.

Personal Information

Full Name________________________ Date of Birth __________ Social Security # ___________________

E-mail Address _________________________________ Marital Status __________ Gender ________

Address _________________________________ City/State__________________ Zip Code____________

Home Number______________ Cellular Number________________ Emergency Number _____________

Employer / Student Information

Employer/School Name _______________________________________Position _____________________

Employer/School Address ____

Employer/School Phone Number ________________________ Supervisor ___________________________

Financial Information

SELF -or- Guarantor's Name ________________________________ Relationship _________________

Address _________________________________ City/State__________________ Zip Code____________

Home Number ____________________________Work Number____________________________________

Employer's Name & Address ____

Social Security Number _______________________________ Date of Birth __________________________

Insurance Information

	DENTAL	MEDICAL
Ins. Company Name		
Phone Number		
Employer		
Employee's Name/DOB		
Policy & Group Number		

Authorization for Services

The signature below serves as authorization for services rendered by Chatham Oral & Maxillofacial Surgery, P.C. for the above named patient, and release of information necessary to file insurance and assign benefits otherwise payable to the policy holder to the doctor indicated on the claim. I understand that I am financially responsible for any balance not covered by the insurance carrier and will be billed for all services after 60 days regardless of insurance status. I understand that a monthly finance charge of 1.5% (18% annual percentage rate) will accrue for any account balance older than 60 days. I also agree to pay all collection fees and court costs in the event of such an occurrence. A copy of the signature is valid as the original.

The signature below also serves as authorization for Chatham Oral & Maxillofacial Surgery, P.C. to release or receive information for the purpose of patient care / referral. A copy of the signature is valid as the original.

Patient/Guardian Signature ____Date__________________