Centre Oral & Facial Surgery, P.C. Dr. Greg Kewitt

PATIENT'S LEGAL NAME: _____
(First) (Middle Int.) (Last) Preferred name

Address: _____ Employer: _____
City, ST Zip: _____ Occupation: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Birth Date: _____ Age: _____ ***Students only:*** Full-time ☐ Part-time ☐
S.S. # _____ Name of School: _____
Marital Status *(circle)*: Single / Married / Divorced / Widowed Local Address (if applicable): _____
Text Authorization: Opt-out ☐ OPT-IN ☐ _____
Email Authorization: Opt-out ☐ OPT-IN ☐ ➡ Email Address: _____

EMERGENCY CONTACT/ HIPAA Disclosure Authorization: Name: _____
Relationship to Patient: _____ Cell Phone: _____ Home Phone: _____

PHYSICIANS:
Referred By: _____ Orthodontist: _____
General Dentist: _____ Family Physician: _____

Who is the person financially responsible for the patient's bill? CHECK HERE IF SELF: ☐

Responsible Party's Name: _____ Email: _____
Relationship to Patient: Spouse ☐ Parent ☐ Financial POA ☐ Medical POA ☐ Other (specify) _____
Address: _____ City, ST Zip: _____
Home Phone/Cell: _____ Birth Date: _____ S.S. #: _____
Is there a second person financially responsible for the patient's bill? *Yes_____ No _____* ***If yes, complete back side***

Provide your PRIMARY INSURANCE cards and complete the information below:

DENTAL INSURANCE: _____ Insurance Phone Number: _____
Policyholder's Legal Name: _____ Birth Date: _____ SS #: _____
Policyholder's Legal Address: _____ Email: _____
Policyholder's Phone Number: _____ Marital Status (circle): Single / Married / Divorced / Widowed
Policyholder's Employers Name: _____
Group # _____ Policy /I.D. # _____ Relationship to Patient: _____
Does patient have secondary dental insurance? *Yes_____ No _____* ***If yes, complete back side***

MEDICAL INSURANCE: _____ Insurance Phone Number: _____
Policyholder's Legal Name: _____ Birth Date: _____ SS #: _____
Policyholder's Legal Address: _____ Email: _____
Policyholder's Phone Number: _____ Marital Status (circle): Single / Married / Divorced / Widowed
Policyholder's Employers Name: _____
Group # _____ Policy /I.D. # _____ Relationship to Patient: _____
Does patient have secondary medical insurance? *Yes_____ No _____* ***If yes, complete back side***

Authorization, release & agreement to pay for services rendered. I authorize the doctor and other dentists or health-care professionals to perform diagnostic procedures and treatment as may be necessary for proper dentofacial care. I authorize the taking of photographs, radiographs and other diagnostic records before, during and after treatment and to use the same by the doctor in scientific presentations or scientific literature. I authorize **Centre Oral & Facial Surgery, P.C.** and its credentialed providers to release any information (via mail, fax or electronically) including the diagnosis and the records of any treatment or examination rendered to me/my child during the period of such Dental/Medical care to third party payors, and other entities and/or health practitioners. I authorize and hereby request my insurance company to pay directly to Centre Oral & Facial Surgery insurance benefits otherwise payable to me. I understand that my dental and or medical insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

_____ _____ _____
Signature of Patient **Signature of Guardian (if minor)** **Date**

This copy of signature is valid as the original. Signature on file is valid indefinitely.

Provide the second person financially responsible for the patient's bill?

Responsible Party's Name: _____ Email: _____
Relationship to Patient: ___Spouse ___Parent ___Financial POA ___Medical POA ___Other (specify) _____
Address: _____ City, ST Zip: _____
Home Phone/Cell: _____ Birth Date: _____ S.S. #: _____

Provide your SECONDARY INSURANCE cards and complete the information below:

DENTAL INSURANCE: _____ Insurance Phone Number: _____
Policyholder's Legal Name: _____ Birth Date: _____ SS #: _____
Policyholder's Legal Address: _____ Email: _____
Policyholder's Phone Number: _____ Marital Status (circle): Single / Married / Divorced / Widowed
Policyholder's Employers Name: _____
Group # _____ Policy /I.D. # _____ Relationship to Patient: _____

MEDICAL INSURANCE: _____ Insurance Phone Number: _____
Policyholder's Legal Name: _____ Birth Date: _____ SS #: _____
Policyholder's Legal Address: _____ Email: _____
Policyholder's Phone Number: _____ Marital Status (circle): Single / Married / Divorced / Widowed
Policyholder's Employers Name: _____
Group # _____ Policy /I.D. # _____ Relationship to Patient: _____