PATIENT INFORMATION

R. JONAS **COLLINS**, DMD
Oral Surgery | Dental Implant Center

Name: _____ Sex: _____ Birthday: _____
FIRST MIDDLE LAST

Home Address: _____
STREET CITY STATE ZIP

Mailing Address (If Different): _____ Cell #: _____

Social Security #: _____ Home Tel. #: _____ Work Tel #: _____

Dentist: _____ Physician: _____

Who may we thank for referring you to our office? _____

INSURANCE INFORMATION

Subscriber: _____ Birthday: _____
FIRST MIDDLE LAST

Address: _____
STREET CITY STATE ZIP

Home Tel. #: _____ Work Tel. #: _____

Relationship to Patient: _____ Social Security #: _____

Employer: _____ Position: _____

Employer's Address: _____
STREET CITY STATE ZIP

Medical Insurance: _____ ID #: _____

Telephone #: _____ Group #: _____

Dental Insurance: _____ ID #: _____

Telephone #: _____ Group #: _____

Name and location of your pharmacy: _____

EMERGENCY CONTACT (Please list relative or friend not living with you.)

Name: _____ Home Tel. #: _____

Home Address: _____
STREET CITY STATE ZIP

Employer: _____ Work Tel. #: _____

CONTRACT TO PAY FOR MEDICAL SERVICES: In consideration of professional services provided to the above patient, I/We agree to pay your customary charge for these services in full, at the time of service. I/We authorize R. Jonas Collins, DMD, PC, to receive assignment of Insurance payments. If the customary charges are more than the benefits allowed under the responsible party's insurance plan, I/We agree to pay the difference. I understand that a finance charge of 1.5% monthly (18% APR) will be added to my outstanding account balance after 60 days. I understand that any default in payment on my account is my/our responsibility and I understand that additional fees will be applied if the account goes to collections.

AUTHORIZATION TO RELEASE INFORMATION: R. Jonas Collins, DMD, PC is hereby authorized to release any medical or incidental information that may be necessary for either medical care or in processing requests for financial benefit.

LEGAL RESPONSIBLE PARTY: If the patient is a minor, or under custodial care, the below responsible party represents that they are legally authorized to obtain medical services for the patient.

Patient's Signature: _____ Date: _____

Responsible Party's Signature: _____ Date: _____