Palm Beach Oral & Maxillofacial Surgery Associates & The Institute of Dental Implants

NEW PATIENT QUESTIONNAIRE

Date: _____

First Name:_____ **Last:**_____ **SS#:**_____

Nickname:_____ **Date of Birth:** _____ **AGE:**_____

Address:_____

City:_____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Referring Physician: _____

Primary Dental Insurance: _____Policy Holder:_____

Address: _____ City: _____ State: ____ Zip: _____

Policy #: _____ Group #:_____ SSN: _____DOB: _____

Employer Name: _____ Work Phone: _____

Relationship to Patient: _____

Primary Medical Insurance: _____Policy Holder:_____

Address: _____ City: _____ State: _____ Zip: _____

Policy #: _____ Group#: _____SSN: _____ DOB: _____

Employer Name: _____ Work Phone: _____Relationship to Patient: _____

Pharmacy Name: _____ Phone #: _____

Current Medications or Supply list: (MAY USE BACKSIDE)_____

Allergies to Medications: _____

**Person to notify in case of emergency:

Name: _____ Address: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____Relationship to Patient: _____

** Please remember 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 fixed allowances 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 by your insurance. IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT. If this account is assigned to an attorney for collection, the prevailing party shall be entitled to reasonable attorney's fees and cost of collection. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record. I hereby assign all medical and/or surgical benefits to which I am entitled to include major medical benefits, private or other health plans to Andrew Slavin, D.M.D. Inc. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature: _____ Date: _____