Regional Oral Surgery Center
Of The Upper Cumberlands

# PATIENT INFORMATION SHEET

FIRST NAME:_____ MIDDLE INITIAL:_____ LAST NAME:_____ SEX: M / F

DATE OF BIRTH:_____ AGE:_____ SOC. SEC#:_____ DRIVERS LIC.#: _____

ADDRESS:_____ CITY:_____ ST:_____ ZIP:_____

HOME PHONE #: ( )_____ PHYSICIAN:_____ DENTIST:_____

BUS. PHONE #: ( )_____ REFERRED BY:_____ SINGLE / MARRIED / OTHER

CELL PHONE #: ( )_____ NICK NAME:_____

EMPLOYED: Full time / Part time / Retired / Not

EMPLOYER NAME:_____

CITY:_____ ST:_____

STUDENT STATUS: Full time / Part time / Not

SCHOOL NAME:_____

CITY:_____ ST:_____

NAME OF SPOUSE:_____

ADDRESS:_____

CITY:_____ ST:_____ ZIP:_____

PHONE:_____ BIRTHDATE:_____

SOC. SEC#:_____

SPOUSE EMPLOYER: _____

CITY:_____ ST:_____ ZIP:_____

EMPLOYER PHONE#:_____

DRIVERS LIC #:_____

**RESPONSIBLE PARENT WITH PATIENT**

NAME:_____

ADDRESS:_____

CITY:_____ ST:_____ ZIP:_____

HOME PHONE:_____ BIRTHDATE:_____

SOC. SEC#:_____ RELATION TO PATIENT:_____

EMPLOYER: _____

CITY:_____ ST:_____ ZIP:_____

EMPLOYER PHONE#:_____ DL #_____

**PERSON OUTSIDE OF YOUR HOUSEHOLD TO NOTIFY IN CASE OF EMERGENCY:**

**NAME:_____ RELATION:_____**

**ADDRESS:_____ CITY:_____ ST:_____ ZIP:_____**

**HOME PHONE #:_____ BUS. PHONE #: _____**

**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. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge of any procedure or surgery you may require will be given to you upon your request. Please remember that insurance is considered a method of reimbursing the patient and is not a substitute for payment.**

*This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment directly to Regional Oral Surgery Center of the insurance benefits otherwise payable to me. I hereby agree to assume the responsibility for payment of all collection agencies' fees, attorney's fees, and all court cost incurred if this account remains outstanding and unpaid in excess of 90 days regardless of insurance. It is understood that the fees of a collection agency and/or attorney may be as much as 50% of the unpaid balance, and will be in addition to the outstanding balance. I hereby also agree to assume responsibility for a 1.5% per month service charge on all unpaid balances over 90 days from the date of service regardless of insurance.*

**SIGNATURE:_____ DATE:_____ WITNESS:_____**

*(SIGNATURE OF PATIENT OR GUARDIAN IF MINOR)*