Welcome to our office…*To provide you with the best care possible we will need the following information completed. All information is strictly confidential.*

Patient Information **Today's Date:**_____

Name_____ Social Security #_____
Birth Date:_____ Home Phone#_____
Address:_____ City_____State_____Zip_____

Employer:_____ Work Phone#_____
Business Address:_____
If Student, Name of School/College_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Person to Contact in Case of Emergency_____
Phone#_____ Relationship to You_____

Name of Dentist:_____ Primary Care Physician:_____

Person responsible for payment if other than patient: ☐ **Not applicable**
Name_____ Relationship to Patient_____
Address:_____
Home Phone#_____Birthdate:_____Social Security Number_____
Work Phone#_____Employer_____

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full is required at each appointment.

☐ *Cash* ☐ *Personal Check* ☐ *Visa* ☐ *Master Card* ☐ *Interested in CareCredit Payment Plan*

Medical Insurance: ☐ **None**

Name of Insurance_____ Subscriber Name_____
Address_____ Social Security Number_____
_____ Birth Date_____
Phone Number_____ Employer_____
Identification Number_____ Relationship to Patient_____
Group Number_____ If retired, retirement date_____

Dental Insurance: ☐ **None**

Name of Insurance_____ Subscriber Name_____
Address_____ Social Security Number_____
_____ Birth Date_____
Phone Number_____ Employer_____
Identification Number_____ Relationship to Patient_____
Group Number_____
How much is your yearly deductible?_____ Maximum Annual Benefit_____

Please present your insurance cards, so we may maintain a copy in your records. If you have additional insurance information, please discuss with office staff.

PLEASE COMPLETE THE NEXT PAGE

Patient Payment Policy

Payment is due at the time services are rendered. To reduce your cost for services, our office does not bill. We accept cash, checks, money orders, and major credit cards. For your convenience, we also offer a flexible, interest-free payment plan through CareCredit. Insurance is provided through a contract between your employer and an insurance company. The coverage you receive is based on terms negotiated between these two organizations. Insurance is considered a method of ***reimbursing*** the patient for the fees paid to the doctor and is not a substitute for payment. Medical insurance, dental insurance, or both cover many oral and maxillofacial procedures, however, **NOT ALL TREATMENT IS COVERED BY INSURANCE**. This office has contracts and participates with certain insurance companies. Some insurance companies do not have contracts with doctors and there are some companies with whom we have chosen not to have a contract. Our office will assist you in obtaining the benefits to which you are entitled, which includes verifying your insurance benefits prior to treatment. However, verification of benefits is not a guarantee of payment. Please keep in mind that you are directly responsible for your account. It is your responsibility to pay any expenses that your insurance does not cover at the time of treatment, including copays, coinsurances, and deductibles, and it will be your responsibility to pay any remaining balance 45 days after treatment. *Insurance information not provided at time of visit will not be accepted after professional services have been rendered.* A monthly service charge will be added to the remaining balances of all accounts over 30 days. The service charge will by 1½ % monthly, 18% annually. In the event it becomes necessary for your account to be referred to our collection agency, collection fees will be added to the amount due, and will become payable to you. **HMO Patients**: You must have a referral from your primary care physician. If you do not have a referral for your office visit or treatment, you are directly responsible for payment in full. *If you miss an appointment for a scheduled surgery without 24 hours notice, you will be charged 25% of the fee of the scheduled procedure.* It may be 5-6 weeks before another appointment is available during our busy seasons.

This signature on file is my authorization for the release of information necessary to process my claim. This information may include, but is not limited to medical/dental records, x-rays, history/physical exam, and financial information. This information may be transmitted electronically. All attempts to maintain confidentiality will be made. I hereby authorize payment of the benefits to this doctor, otherwise payable to me. I understand this office's payment policy as described above and agree to these terms.

_____ _____

Patient/Responsible Party Signature Date

Suburban Oral Surgery, P.C.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting Alfred J. Wolanin, Jr., D.D.S., at 2010 West Chester Pike, Havertown, PA 19083, telephone number 610-449-2100.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations. I also acknowledge that I have received a copy of this office's notice of privacy practices and have a right to a copy of this Consent after I sign it. Signature:_____Date:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's Name:_____ Relationship to Patient:_____

REVOCATION OF CONSENT: I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I revoke my consent

SIGNATURE:_____ DATE:_____