

RAYMOND L. WIGGINS, D.D.S., M.D.
Diplomate of the American Board of Oral and Maxillofacial Surgery
TEXAS ORAL AND FACIAL SURGERY, P.A.
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PATIENT INFORMATION

Name: _____ DOB: _____ Sex: _____
Last First Middle

Home Address: _____
Street City State Zip

Mailing Address (If Different): _____

Patient SS# _____ Home Phone: _____ Work Phone _____

Cell Phone _____ Pager _____ TDL _____

Dentist: _____ Address: _____

Phone: _____

Physician: _____ Address: _____

Phone: _____

INSURANCE INFORMATION

Responsible Person: _____ DOB: _____
Last First Middle

Address: _____
Street City State Zip

Home Telephone: _____ Work Telephone: _____

Relationship to Patient: _____ SS#: _____ TDL# _____

Employer: _____ Position: _____

Employer's Address: _____
Street City State Zip

Insurance Co.: _____ Group #: _____

Contract/Account Number: _____ Effective Date: _____ Medical Dental

Second Insurance Co.: _____ Group #: _____

Contract/Account Number: _____ Effective Date: _____ Medical Dental

Please complete next page

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

Name: _____ Home Telephone: _____
Last First Middle

Home Address: _____
Street City State Zip

Employer: _____ Work Telephone: _____

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

CONTRACT TO PAY FOR MEDICAL AND DENTAL 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, unless other arrangements are made with Texas Oral and Facial Surgery, P.A. I/we authorize Texas Oral and Facial Surgery, P.A. 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.

MEDICARE. Texas Oral and Facial Surgery, P.A., is a **non-participating** provider under the Medicare program. However, Medicare does not cover most oral and maxillofacial surgery procedures. Medicare patients are personally responsible for full payment for services received which are not paid by Medicare.

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 and make financial arrangements for the patient's care.

PRIVACY OF INFORMATION AND AUTHORIZATION TO RELEASE INFORMATION. It is the policy of Texas Oral and Facial Surgery, P.A. to maintain the privacy of all patient transactions. Texas Oral and Facial Surgery, P.A. 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. A copy of our Privacy Policy is available for your review.

CONSENT FOR LABORATORY TESTING. In the event that any of the office staff of Texas Oral and Facial Surgery, P.A. is injured while performing patient treatment (i.e. needle stick, puncture wound, etc.), Texas Oral and Facial Surgery, P.A. has my full consent to draw blood for the purpose of laboratory testing. This will ensure the safety of all parties who are concerned and involved.

Patient's Signature

Date

Responsible Party's Signature

Date