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.
810 South Mason Road · Suite 301 · Katy, TX 77450
Office: 281.395.1200 · Fax: 281.395.1201· www.txofs.com

PATIENT INFORMATION

Name: _____(_____) DOB: _____ Sex: _____
Last First Middle Nickname/Preferred Name

Home Address: _____
Street City State Zip

Mailing Address (If Different): _____

Cell Phone_____ Home Phone_____ Work Phone_____

Email: _____

SS#_____TDL#_____

Dentist: _____ Phone: _____

Physician: _____Phone:_____

College Student Status: FT PT Name of School Attending: _____

INSURANCE INFORMATION

Responsible Person: _____ DOB: _____
Last First Middle

Address: _____
Street City State Zip

Cell Phone_____ Home Phone_____ Work Phone_____

Responsible Person's Email:_____

Relationship to Patient: _____ SS#: _____TDL#_____

Employer: _____ Position: _____

Employer's Address: _____
Street City State Zip

Insurance Co.: _____ Group #: _____

Contract/Account Number: _____ ❒ Medical ❒ Dental

Second Insurance Co.: _____ Group #: _____

Contract/Account Number: _____ ❒ Medical ❒ Dental

Please complete next page

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

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

Name: _____ Home Telephone: _____
Last *First* *Middle*

Home Address: _____
Street City State Zip

Email_____

Employer: _____ Work Telephone: _____

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) may 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