ROANOKE ORAL SURGERY, INC.
6035 PETERS CREEK ROAD
ROANOKE, VA 24019
(540) 362-5900

# ROANOKE ORAL SURGERY, INC.

PRACTICE LIMITED TO ORAL & MAXILLOFACIAL SURGERY

## GENERAL INFORMATION

ACCT.#_____

**PATIENT FULL NAME:** _____ **DATE OF BIRTH:**_____

Mailing Address: _____City _____ State_____ Zip _____

Street Address:_____City _____ State_____ Zip _____

Home Phone: ( _____ )_____ Cell Phone: ( _____ )_____

Age: _____ Sex: _____ Marital Status: _____ SSN:_____

Patient Employed By: _____ How Long?_____ Occupation: _____

Employer's Address: _____ Phone: _____

Parent/Spouse Name : _____DOB: _____ SSN: _____

Parent/Spouse Employed by: _____ Phone: _____

Person Responsible for patient's bill (if different from above): _____SSN:_____

Relation to patient: _____ Address: _____ Employer:_____

Person to notify in case of emergency (if different from above): _____

Phone (during the day): _____ Relationship: _____

Have you ever been a patient here before? _____ Approximate Date: _____

Have any members of your family been patients here before?____ Name: _____ Approx. Date:_____

Family Dentist: _____ Orthodontist: _____

Family Physician: _____ Who referred you to this office? _____

## INSURANCE INFORMATION

**IN ORDER FOR US TO PROPERLY FILE A CLAIM FOR SERVICES RENDERED IN OUR OFFICE, THE FOLLOWING INFORMATION MUST BE SUPPLIED.**

**DO YOU HAVE DENTAL INSURANCE?** ☐Yes ☐No Relationship of patient to policyholder: ☐Self ☐Spouse ☐Child

Name of Dental Insurance Company: _____

ID. # of Policyholder:_____ Group #:_____

Name of Policyholder: _____ Date of Birth: _____SSN:_____

Policyholder's Place of Employment: _____

**DO YOU HAVE MEDICAL INSURANCE?** ☐Yes ☐No Relationship of patient to policyholder: ☐Self ☐Spouse ☐Child

Name of Medical Insurance Company: _____

ID. # of Policyholder:_____ Group #:_____

Name of Policyholder: _____ Date of Birth: _____SSN:_____

Policyholder's Place of Employment: _____

**DO YOU HAVE MEDICAID OR MEDICARE? _____Yes _____ No**

IF WE PARTICIPATE WITH YOUR INSURANCE YOU WILL BE REQUIRED TO PAY ALL COPAYS AND UNMET DEDUCTIBLES AT THE TIME OF SERVICE. IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE, PAYMENT IN FULL IS REQUIRED AT THE TIME OF SERVICE. IF YOU PROVIDE A COPY OF YOUR INSURANCE CARD WITH ALL PERTINENT INFORMATION, AS A COURTESY, WE WILL FILE YOUR INSURANCE CLAIM FOR YOU. BY SIGNING BELOW YOU ARE AUTHORIZING ASSIGNMENT OF INSURANCE BENEFITS, PAYABLE TO YOU ON YOUR BEHALF, TO ROANOKE ORAL SURGERY, INC. THIS SIGNATURE SERVES AS A REQUEST FOR PAYMENT FOR SERVICES RENDERED BY ALBERT W. PARULIS, JR. D.M.D., JASON I. MARGOLIS, D.M.D. OR KAINE K.S. STOKES, D.D.S. YOUR SIGNATURE BELOW ALSO AUTHORIZES THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS YOUR INSURANCE CLAIM.

FOR YOUR CONVENIENCE, WE ACCEPT MASTERCARD, VISA, & DISCOVER. A MINIMUM FINANCE CHARGE OF FIFTY CENTS PER MONTH OR FINANCE CHARGES AT THE RATE OF 1% PER MONTH (12 APR) WILL ACCRUE ON ANY UNPAID BALANCE 90 DAYS FROM THE DATE OF SERVICE IN THE EVENT THAT IT BECOMES NECESSARY TO TURN YOUR ACCOUNT OVER TO A COLLECTION AGENCY, YOU WILL BE RESPONSIBLE FOR PAYMENT IN FULL OF YOUR ACCOUNT PLUS ALL THE COLLECTION COSTS.

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DATE SIGNATURE OF PATIENT OR LEGAL GUARDIAN RELATIONSHIP TO PATIENT IF MINOR