Stepanyan Surgical Arts Center

FACIAL COSMETIC & RECONSTRUCTIVE SURGERY

ORAL & MAXILLOFACIAL SURGERY

PATIENT REGISTRATION INFORMATION

GENERAL INFORMATION

Last Name **First Name** **Middle** **Birth Day** **Age**

Home Address **City** **State** **Zip** **Phone Number**

Place of Employment **Occupation / Position**

Employment Address **City** **State** **Zip** **Phone Number**

Name of School if Currently a Student

Social Security Number **Driver's License Number / State** **Male Female Sex (please circle)**

Married Single
Marital Status **Name of Spouse**

MEDICAL / DENTAL INFORMATION

Family General Dentist Name

Address **City** **State** **Zip** **Phone Number**

Family Physician Name / Medical Group

Address **City** **State** **Zip** **Phone Number**

Emergency Contact **Relationship** **Home Phone Number** **Work Phone Number**

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

I.e. Dentist, Physician, Friend, Family Member, Insurance Plan, Yellow Pages (type), other

WE REQUEST PAYMENT AT THE END OF EACH VISIT UNLESS ARRANGEMENTS HAVE BEEN PREVIOUSLY MADE WITH OUR OFFICE.

PLEASE CHECK YOUR PREFERRED FORM OF PAYMENT.

Cash _____ Check _____ Visa / MC___

PRIMARY RESPONSIBLE PARTY INFORMATION *(individual responsible for payment)*

Same as patient registration information: Yes _____ (No need to complete this section) No _____ (Please complete section below)

Last Name **First Name** **Middle** **Birth Day** **Age**

Home Address **City** **State** **Zip** **Phone Number**

Place of Employment **Occupation / Position**

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Employment Address **City** **State** **Zip** **Phone Number**

Male Female

Social Security Number **Driver's License Number / State** **Sex (please circle)**

Parent **Legal Guardian** **Spouse** **Other**

Relationship with Patient: (please circle)

INSURANCE INFORMATION (please be as complete as possible / a photo copy of your insurance card can be acceptable)

Primary Dental Insurance Company **Name of Insured Individual**

Insurance Company Address **City** **State** **Zip** **Policy Number** **Group Number**

Secondary Dental Insurance Company **Name of Insured Individual**

Insurance Company Address **City** **State** **Zip** **Policy Number** **Group Number**

Primary Medical Insurance Company **Name of Insured Individual**

Insurance Company Address **City** **State** **Zip** **Policy Number** **Group Number**

Secondary Medical Insurance Company **Name of Insured Individual**

Insurance Company Address **City** **State** **Zip** **Policy Number** **Group Number**

ASSIGNMENT OF BENEFITS: *I hereby assign all dental, medical, and / or surgical benefits for private insurance to* ***Stepanyan Surgical Arts Center*** *A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all necessary information to secure payment for all services.*

Responsible Party Signature **Date**

MEDICARE WAIVER OF LIABILITY FOR PAYMENT: *I hereby understand that the procedures and/or treatment I may receive potentially may not be deemed reasonable or necessary by MEDICARE reviewers. This in no way reflects upon the quality of services provided by* ***Stepanyan Surgical Arts Center****, Even though, I agree to be responsible for all and any appropriate payment for services rendered by* ***Stepanyan Surgical Arts Center*** *that are not deemed reasonable or necessary by MEDICARE reviewers.*

Medicare Patient Signature **Date**

******** ***THANK YOU FOR YOUR TIME AND COOPERATION IN COMPLETING THESE IMPORTANT FORMS*** ********