Midwest Oral & Craniofacial Specialists

Patient Information

Patient Last Name: _____ Patient First Name: _____
Middle Initial:____ Patient Preferred Name/Nickname: _____ Gender:_____
Date of Birth (MM/DD/YYYY):_____ Address:_____
City: _____ State: _____ Zip: _____ Cell Phone: _____
Other Phone: _____ Email: _____
Primary Care Physician: _____ Office Phone: _____
Person Who Referred You to Us:_____

Person to Contact in Case of Emergency:
Name:_____ Relation:_____ Cell Phone: _____
Other Phone(s):_____ Email:_____

Primary Responsible Party Information

Person/Party Financially Responsible for Account
Note: Insurance companies are NOT considered responsible parties.

Last Name:_____ First Name:_____ Date of Birth:_____
Relationship to Patient: _____Address:_____
City:_____ State:_____ Zip:_____Phone:_____

Primary Medical Insurance

Insurance Plan:_____
Telephone:_____
Address:_____
City:_____ State:_____ Zip:_____
Policy Number:_____
Group Number:_____
SSN of Policy Holder:_____
Policy Holder Name:_____
Employer of Policy Holder:_____
Policy Holder Date of Birth:_____
Patient's Relation to Insured:_____

Secondary Medical OR Dental Insurance

(Optional)

Insurance Plan: _____
Telephone:_____
Address:_____
City:_____ State:_____ Zip:_____
Policy Number:_____
Group Number:_____
SSN of Policy Holder:_____
Policy Holder Name:_____
Employer of Policy Holder:_____
Policy Holder Date of Birth:_____
Patient's Relationship to Insured: _____

By signing below, I authorize release of any and all necessary information to my insurance provider to generate payment and for this practice to receive payment directly. ***I understand* and *agree* that I** am ***financially responsible* for the balance on *my account regardless* of *insurance status*. If *this account should become delinquent*, I *understand that* I will *be held responsible* for *any and all costs/fees/additional charges stemming from collection efforts.***

☐ I consent to receive informational, conversational, and promotional SMS text messages from Midwest Oral and Craniofacial Specialists at the number provided, including messages sent by autodialer. Consent is not a condition of service. Msg & data rates may apply. Msg frequency varies. Unsubscribe at any time by replying STOP or clicking the unsubscribe link (where available). Reply HELP for help. Visit www.midwestcranio.com/privacy-policy to see our privacy policy and for our Terms of Service.

_____

Patient Signature **Date**