IMPACT

oral surgery

Affiliate of RockDental BRANDS

PATIENT INFORMATION FORM

Patient Name _____ Birthday _____

Sex: ☐ Male ☐ Female Marital Status _____

Physical Address _____ City _____ State _____ Zip_____

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address _____

Patient Employer _____ Employer's Address _____

City _____ State _____ Zip_____ Patient SS # _____

Responsible Party Name_____ Birthday _____

Insurance Carrier _____ SS # _____

Employer _____ Employer's Address _____

Emergency Contact _____ Relationship _____ Phone_____

Referring Physician / Office _____ Phone _____

Please have your driver's license and insurance card available for us to make a copy for your records.

I hereby authorize payment of medical/dental benefits to Impact Oral Surgery for services rendered and agree that the entire bill is my responsibility, regardless of what my insurance coverage may be. Once my dentist obtained my one-time authorization, he may submit and later claim on assigned or unassigned basis without obtaining any additional signature.

We require a 48-hour notice for cancelling sedation appointments; otherwise you maybe charged a $250.00 cancellation/missed appointment fee.

Payment is due the day services are rendered.

Signature Date

JOSHUA LEAL, DDS

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