EDWARDSVILLE ORAL SURGERY & IMPLANT CENTER

1005 PLUMMER DRIVE ● SUITE #A ● EDWARDSVILLE, IL 62025 ● PHONE (618) 656-3100 ● FAX (618)656-3146

TO ALL OUR PATIENTS

Welcome! Thank you for selecting our office. It is our goal to provide for your oral and maxillofacial surgery needs as thoroughly and efficiently as possible. In addition, we will endeavor to make your visit with us a pleasant and comfortable one. Please read and complete the following materials, and don't hesitate to ask if you have any questions.

date_____

PATIENT REGISTRATION

_____ (_____)_____ (_____)_____
title, first, mi, last | home phone | cell phone

_____ (_____)_____
street address / mailing address | work phone ext.

_____ _____
city, state, zip | social security number

_____ _____/_____/_____ _____ _____ _____
age | birth date | marital status | sex | employer's name

_____ _____
occupation | employer's address

PERSON RESPONSIBLE FOR ACCOUNT

_____ (_____)_____ (_____)_____
title, first, mi, last | home phone | cell phone

_____ _____ (_____)_____
street address / mailing address | relationship | work phone

_____ _____
city, state, zip | social security number

_____ _____/_____/_____ _____ _____ _____
age | birth date | marital status | sex | employer's name

_____ _____
occupation | employer's address

INSURANCE INFORMATION: DENTAL INSURANCE

_____ID#_____ _____
PRIMARY company | social security number

_____ _____ _____
member's name | birth date | group

_____ID#_____ _____
SECONDARY company | social security number

_____ _____ _____
member's name | birth date | group

INSURANCE INFORMATION: MEDICAL INSURANCE

_____ID#_____ _____
PRIMARY company | social security number

_____ _____ _____
member's name | birth date | group

_____ID#_____ _____
SECONDARY company | social security number

_____ _____ _____
member's name | birth date | group

PLEASE SEE OTHER SIDE TO COMPLETE FORM.....

MISCELLANEOUS INFORMATION

_____ _____
Referring dentist physician's name

Has any member of your family ever been a patient here? Yes **O** No **O**

_____ _____
if so, name/relationship name/relationship

_____ _____
name/relationship name/relationship

AUTHORIZATION TO OBTAIN AND RELEASE INFORMATION

I authorize Dr. Hyten and his designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of information acquired in the course of my examination and treatment. I authorize Dr. Hyten to obtain or release my treatment, insurance, billing and appointment information to the following individuals, in addition to my referring physician, until I revoke the authorization in writing:

1) _____ 2) _____

_____ _____
Insured or Guardian's Signature Patient's Signature

FINANCIAL AGREEMENT

Methods of Payment: Cash, Check, MasterCard, Visa, Discover, Insurance, Healthcare Credit Line.

Insurance: We are pleased you have insurance, and our office will assist you in obtaining the maximum benefits specified in your contract. We are not a party to your insurance contract, but as a courtesy to you, we will file your insurance claim and accept an assignment of benefits. We require that your estimated co-payment and deductible be paid at the time of service. You will need to confirm with your provider whether a particular procedure is covered under your contract.

Hereforth:

1. I agree to pay the amount charged by the doctor for all professional treatment and services to the undersigned, his/her family, or to the patient.
2. Past due accounts will be subject to a finance charge at the rate of 1 ½ percent per month from the date of delinquency. The date of delinquency shall be 90 days from the date of service.
3. A $25 fee will be applied to all returned checks.

Furthermore:

I hereby authorize payment of my insurance benefits directly to the office of Edwardsville Oral Surgery & Implant Center. I realize that I am financially responsible for all charges regardless of insurance coverage. I further agree to pay any costs incurred by Edwardsville Oral Surgery & Implant Center and/or Steven J. Hyten, P.C., to effect collection on this account, including reasonable attorney fees, whether or not a lawsuit is filed. Any lawsuit arising from this agreement shall be heard exclusively in the Circuit Court of Madison County, Illinois, and I irrevocably consent to the jurisdiction of same. I further agree to waive my rights to a jury trial for any dispute arising from this agreement. If a court finds any provision of this agreement unenforceable, the parties agree that any unenforceable provision shall be severed from the agreement and the remaining terms shall remain in full force and effect.

_____ _____
Insured or Guardian's Signature Patient's Signature