ACQUAINTANCE SLIP

It is a pleasure to welcome you to our office. Please fill out the following form to aid us in preparing your clinical records. All information given to us will be strictly confidential.

Greater Louisville Oral & Maxillofacial Surgery Associates, P.S.C.

PATIENT INFORMATION

❑ Miss
❑ Mr.
Name ❑ Mrs. _____ Birthdate _____ Age _____ Preferred Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ SS# _____

If Student, Name of School/College _____ City _____ State _____ Zip _____ ❑ FT ❑ PT

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

How did you hear about our office?

Yellow Pages ____ Ad ____ Friend/Relative ____ Dentist _____ Physician _____

Person to contact in case of emergency _____ Phone _____

RESPONSIBLE PARTY

❑ CHECK HERE IF SAME AS ABOVE

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Drivers License # _____ Birthdate _____ SS # _____

Employer _____ Work Phone _____

Is this Person Currently a Patient in our Office? ❑ Yes ❑ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

❑ Cash ❑ Personal Check Credit Card ❑ Visa ❑ MasterCard ❑ I wish to discuss the office's payment policy.

_____ All Personal items are the responsibility of the patient and/or guardian. GLOMSA is not responsible for any lost or stolen items.

DENTAL INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS #/SIN _____ Date Employed _____

Name of Employer _____ Union or Local# _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID # _____

HEALTH INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS #/SIN _____ Date Employed _____

Name of Employer _____ Union or Local# _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID # _____

I authorize the release of information regarding examination or treatment. I permit payment to be made directly to the Oral Surgeon for any benefits due. I accept personal responsibility for payment of fees at time service is rendered and authorize the release of information by my employer pursuant to collection of these fees.

I understand GLOMSA and any affiliates or vendor thereof, including collection or billing companies, may contact me by telephone to any telephonic number I have provided, and any other telephone number associated with my account, including wireless or mobile telephone numbers. I further agree that you may use any method of contact to those numbers, such as an Automated Telephone Dialing System (ATDS) or prerecorded message. I also agree that I will notify GLOMSA if I have given up ownership or control of any such telephone number.

Signed (Patient or Parent of Insured) _____ Date _____