Alliance Oral and Maxillofacial Surgery, P.A.

David E. Parmer, D.D.S., M.D. James R. Macholl, D.D.S., M.D.

Patient Name: _____

DENTAL INSURANCE INFORMATION

Insured: Patient / Spouse / Parent (CIRCLE ONE)
Name of Insured: _____
Birthday of Insured: _____
SS# of Insured: _____
Employer of Insured: _____
Insurance Company Name: _____
Insurance Company Phone #: _____
Subscriber ID #: _____
Group #: _____

MEDICAL INSURANCE INFORMATION

Insured: Patient / Spouse / Parent (CIRCLE ONE)
Name of Insured: _____
Birthday of Insured: _____
SS# of Insured: _____
Employer of Insured: _____
Insurance Company Name: _____
Insurance Company Phone #: _____
Subscriber ID #: _____
Group #: _____

Is the patient a college student? YES NO Full time? YES NO
School Name and Location: _____

PLEASE READ THIS CAREFULLY

You are entering into a relationship with the doctor, in which the doctor agrees to treat the patient and the patient agrees to pay the doctor's fee for treatment. As a courtesy we will assist you by filing your claim to your primary insurance company for all office visits. On the day of surgery you will pay your estimated portion of the total fee. Keep in mind; this amount is based on what your insurance company has told us regarding what they will pay for the surgery. **Please remember, these are only estimates and are not always accurate. If we are misquoted by your insurance company, we are not responsible for their mistake and you will be billed for the amount your insurance company does not pay.** A pre-treatment estimate can be sent by our office to your insurance company and is the most accurate estimate that can be obtained. If you would like to wait on a pre-treatment estimate, please inform our office. Once insurance has paid, you will be billed or refunded accordingly.

For the purpose of filing claims/Insurance verification, I authorize the release of any information and I assign benefits to the doctor. By signing below, I agree to the above terms of financial responsibility.

_____ _____
Signature of Patient or Authorized Representative Date