

DR. RONEN GOLD

BOARD CERTIFIED, AMERICAN BOARD OF ORAL AND MAXILLOFACIAL SURGERY
ORAL AND MAXILLOFACIAL SURGERY OF WESTFIELD

PATIENT NAME: (Mr. Mrs. Ms. Dr.) _____

Today's Date: _____

First Name: _____ Middle Initial: _____ Last Name: _____
Date of Birth: _____ Age: _____ Social Security No.: _____ Sex: Male Female
Address: _____ Apt# _____
City: _____ State: _____ Zip: _____
Home Telephone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____
Dentist: _____ Physician: _____ Referred by: _____
Parent Name (if patient is minor or dependent): _____ Social Security # _____
Parent Address _____ Parent Phone# _____

In case of emergency, please notify:

Name: _____ Contact Number: (____) _____ Relationship: _____

Student: Full time: Part time: N/A School Name: _____

Marital Status: Single Married Divorced Legally Separated Widow

Employed: Full time Part time Retired Unemployed

MEDICAL Insurance Co. _____ ID No.: _____

Employer Name: _____ Group No.: _____

Subscriber: Name _____ Social Sec.No.: _____ Date of Birth: _____

DENTAL Insurance Co. _____ ID No.: _____

Employer Name: _____ Group No.: _____

Subscriber: Name _____ Social Sec.No.: _____ Date of Birth: _____

Do you have Secondary Insurance? Yes No Medical Dental

Secondary Insurance Company Name: _____

Group Name.: _____ Group No.: _____

Subscriber Name: _____ BirthDate: _____ SS# _____

I hereby authorize the release (both written and verbal) of all treatment and account information to:

Name: _____ Relationship: _____

Signature: _____ Date: _____

How will you be paying for today's visit: Credit Card (Visa, Mastercard, or Discover) Cash

**PATIENT FINANCIAL RESPONSIBILITY FOR ANY SERVICES RENDERED BY
DR. RONEN GOLD/ORAL AND MAXILLOFACIAL SURGERY OF WESTFIELD:**

Please remember that insurance is not a substitute for payment. It is your responsibility to pay for all unreferred or non-covered services, deductibles, co-insurance or any other balance not paid for by your insurance company. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. I hereby authorize payment directly to the doctor named of the benefits otherwise payable to me. This signature acknowledges financial responsibility, authorizes release of information & payment directly to the doctor or group.

Signature: _____ Date _____