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

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MEDICAL Insurance Co.____ ID No.:____________________

Employer Name: ____Group No:____________________

Subscriber: Name________________________ Social Sec.No.:______________ Date of Birth:_________________

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DENTAL Insurance Co.____ ID No.:____________________

Employer Name: ____Group No:____________________

Subscriber: Name________________________ Social Sec.No.:______________ Date of Birth:_________________

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Do you have Secondary Insurance? Yes No Medical Dental

Secondary Insurance Company Name: ____

Group Name.: ____Group No.: ______________________________

Subscriber Name: ______________________________________BirthDate:______________SS#_____________

I herby 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

☐ Care Credit

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**________________________