HUGH P. BRINDLEY, D.M.D., P.A.
PRACTICE LIMITED TO
ORAL AND MAXILLOFACIAL SURGERY

PATIENT INFORMATION SHEET
TODAY'S DATE: ______________________ (PLEASE PRINT)

PATIENT'S NAME ______________________
ADDRESS ______________________
CITY ______________ STATE ______________ ZIP CODE ______________
SOC. SEC. # __________ HOME PHONE __________ WORK PHONE __________ CELL __________
AGE ______ BIRTHDATE (M/D/Y) ______________ MARITAL STATUS __________ SEX: M F
EMPLOYED BY ______________________

DENTIST ______________________ PHYSICIAN ______________________
REFERRED BY: ______________________

PERSON RESPONSIBLE FOR ACCOUNT: ______________________
(If different from patient - relationship to patient) ______________________
ADDRESS ______________________
CITY ______________ STATE ______________ ZIP CODE ______________
SOC. SEC. # __________ HOME PHONE __________ WORK PHONE __________ CELL __________
EMPLOYED BY ______________________

DENTAL INSURANCE ______________________
ADDRESS ______________________
CITY ______________ STATE ______________ ZIP CODE ______________
NAME IN WHICH THE INSURANCE IS LISTED ______________________ D.O.B. ______________
ID#/SS# ______________________ GROUP # ______________________
EMPLOYER: ______________________ EMPLOYER PHONE: ______________

MEDICAL INSURANCE ______________________
ADDRESS ______________________
CITY ______________ STATE ______________ ZIP CODE ______________
NAME IN WHICH THE INSURANCE IS LISTED ______________________ D.O.B. ______________
ID#/SS# ______________________ GROUP # ______________________
EMPLOYER: ______________________ EMPLOYER PHONE: ______________

We will file insurance at no extra charge; however, responsibility for the account remains with you, the patient, or responsible party. If insurance is filed, we MUST have all the correct insurance information on the date the initial service is rendered. It is your responsibility to make sure we have accurate insurance information to file the claim correctly. If the insurance company does not pay Dr. Hugh P. Brindley within 60 days of the date of service, the undersigned will be responsible for making payment in its entirety. There may be a fee for any additional filing to your insurance other than the initial claim filed for the date of service. (Insurance claims are filed 1-7 days after the date of service.)

The undersigned hereby agrees to pay all costs of collection including reasonable attorney fees, in the event the debt is turned over for collection. PLEASE NOTE: THERE WILL BE A $35 CHARGE ON ALL RETURNED CHECKS AND THERE WILL BE FINANCE CHARGES ON ALL PAST DUE ACCOUNTS BEYOND 60 DAYS FROM THE DATE OF SERVICE IN THE AMOUNT OF 1% MONTHLY OR 12% ANNUALLY.

SIGNATURE **X** ______________________

I HEREBY AUTHORIZE RELEASE OF ANY MEDICAL RECORDS AND PAYMENT FROM INSURANCE COMPANY DIRECTLY TO HUGH P. BRINDLEY, D.M.D., P.A.

SIGNATURE: **X** ______________________

over

PATIENT CONTACT SHEET

The person(s) listed below may be contacted in reference to my medical/dental care and/or in case of a medical/dental emergency.

Name: ______________________________ Relationship: ______________
Phone # ______________________________

Name: ______________________________ Relationship: ______________
Phone # ______________________________

Name: ______________________________ Relationship: ______________
Phone # ______________________________

Name: ______________________________ Relationship: ______________
Phone # ______________________________