ATLANTIC ORAL SURGERY CENTER, INC.

21 GILBERT ST NORTH. SUITE 210. TINTON FALLS, NJ 07701
732.747.0993

PLEASE COMPLETE THIS FORM ENTIRELY (front & back)

Date: _____

Patient Information:

Name:_____
SSN: _____-_____-_____
DOB: ___/____/_____ **Sex**: _____

Address: _____
_____

Phone: HOME _____ Ext.
WORK _____ Ext.
CELL _____ Ext.

Email: _____
Marital Status: _____
Employment Status: _____

_____

Clinical Information
Allergies:_____

Current Medications: _____
_____

Insurance Information
Primary Carrier:_____ Plan: _____

Primary Guarantor Name: _____

Primary Guarantor DOB: ___/____/_____ **SSN**: _____-_____-_____

Subscriber ID: _____
Group Num: _____

Carrier Address: _____
_____
Carrier Phone: _____ Ext.

Secondary Carrier:_____ Plan: _____

Secondary Guarantor Name: _____

Secondary Guarantor DOB: ___/____/_____ **SSN**: _____-_____-_____

Subscriber ID:_____
Group Number: _____

Carrier Address: _____
_____
Carrier Phone: _____ Ext.

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Financial Information

Method Of Payment For Services Rendered: Select: Cash Check CreditCard

Current Balance:

FINANCIAL POLICY

Full payment is due at the time of service. Financing is available through our credit partner, CareCredit. Please ask for information if you are interested. Insurance is accepted as partial payment, depending on the type of coverage you have. The patient portion, or coinsurance, is due on the day of service.

You will be charged $25 for each time your check is returned from the bank. If your account is turned over to a collection attorney, your balance will increase by 33% PLUS court and collection costs in addition to interest allowable by law.

REGARDING INSURANCE

As a courtesy to patients, we will do our best to work with insurance companies in regards to payment for services rendered. Your benefit policy is a contract between you and your insurance company. We encourage patients to contact their insurance companies to help expedite the process. Please be advised that we cannot bill insurance companies unless provided with accurate and complete patient and policy information.

Please be aware some of the services provided may not be covered by the contract you have with your insurance carrier. The patient or guardian is responsible for all fees regardless of the insurance company's determination of benefits.

Payment for the entire treatment must be paid within 60 days of treatment by either the patient, insurance company, or a combination of both. After this period of time, a finance charge of 2.00% per month will be added to the balance until paid in full.

By signing below, I certify that the above information is accurate and that I agree to the provided policies.

Signed:_____**Print Name**:_____**Date**:_____