GALLATIN VALLEY SURGICAL ARTS

PATIENT REGISTRATION FORM

LEGAL FIRST NAME | MIDDLE INITIAL | LAST NAME

STREET | CITY | STATE | ZIP CODE

HOME PHONE | WORK / CELL | SOCIAL SECURITY #

DATE OF BIRTH | AGE | EMAIL ADDRESS | ☐ MALE OR ☐ FEMALE

REFERRED BY | DENTIST / ORTHODONTIST

ORTHODONIST/OTHER DENTAL SPECIALIST | GENERAL PHYSICIAN

EMERGENCY CONTACT NAME | RELATIONSHIP | PHONE NUMBER

FINANCIALLY RESPONSIBLE PARTY INFORMATION

Payment is expected in full at the time of service unless prior arrangements are made. Estimated charges may vary upon completion of service. Every effort will be made to accurately quote charges. Insurance will be filed but it is the patient's responsibilty to follow up or appeal. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. All checks returned as non-sufficient funds (NSF) may be assessed a $35.00 fee.

It is the patient's responsibilty to pay any deductible amount, co-insurance, or any other balance not paid by insurance. Should this account be turned over to collections, the patient may be responsible for all collection fees, attorney's fees, interest, and court costs.

We accept cash, checks, MasterCard, Visa, American Express, Discover Card, and Care Credit as payment.

PATIENT SIGNATURE (IF UNDER 18, GUARDIAN SIGNATURE) | DATE

FINANCIALLY RESPONSIBLE INFORMATION (if patient is under 18)

FIRST NAME | LAST NAME | RELATIONSHIP

STREET | CITY | STATE | ZIP CODE

DATE OF BIRTH | AGE | SOCIAL SECURITY # | ☐ MALE OR ☐ FEMALE

NOTICE OF PRIVACY PRACTICES

I have had the opportunity to review the Gallatin Valley Maxillofacial & Aesthetic Surgery Notice of Privacy Practices.

PATIENT SIGNATURE (IF UNDER 18, GUARDIAN SIGNATURE) | DATE