Today's Date: **Armitage Oral Surgery** Chart Number:

Patient Information: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Mx. ☐ Dr.

Patient's Name:		Legal Guardian, if patient is a minor:	
Street Address	City	State	Zipcode
Birth date:	**Social Security number:**	Sex: ☐ Male ☐ Female ☐ Non-Binary	

Reason for your visit today, be specific:

Occupation: Employer/Address: Employer Phone:

Patient's Dentist Name Phone

Address

Contact Information

Home: Cell: Work: Email:	Emergency Contact Name: Phone: Relationship:

I authorize Dr. Katabi / Dr. Smythe or a member of his staff to discuss any Protected Health Information with:

Name:_____ Relationship: _____ Phone: _____

Name:_____ Relationship: _____ Phone: _____

Referred to Armitage Oral Surgery by:

☐ Dentist _____ ☐ Other _____

INSURANCE INFORMATION *Please give your insurance cards to the receptionist*

Is Patient covered by insurance: ☐ Yes ☐ No

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Subscriber's Name:	Subscriber's Address	Subscriber phone:
Subscriber's Birth date:	Name of Primary Insurance:	Subscriber's SSN:
Policy no./ID:	Group #:	Subscriber's Employer:

Form of Payment for today's Procedure: ☐ Cash ☐ Check ☐ Credit Card ☐ Care Credit

Please Read Carefully:

- I understand **all fees are the responsibility of the patient or responsible adult (if patient is a minor)** ***regardless of insurance claims or other benefits.***
- I understand that Dr. Katabi / Dr. Smythe are not Medicare providers, ***therefore, Medicare will not be billed.*** If you wish to use your Medicare benefits, you can choose to see a Medicare provider.
- If, after 60 days, my insurance company has not paid **I understand I am still responsible for the bill** and will incur the monthly finance charge of 1.5% (18% annual) on ***any*** **unpaid balance after 60 days, even if insurance has not paid their portion.**
- I authorize the release of any medical or other information necessary to process this claim.
- I hereby authorize insurance payments directly to the doctor of benefit for his services provided to me.
- I give permission to contact any of the phone numbers provided by myself.
- I understand **no pictures or video** will be allowed by anyone other than office staff.

Signature: _____ **Date:**