ARIZONA CENTER FOR ORAL, FACIAL & DENTAL IMPLANT SURGERY

MARVIN D. GOLDENSTEIN, D.D.S.
ORAL AND MAXILLOFACIAL SURGEON

Las Palmas Medical Plaza
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Fax (602) 992-8897

PATIENT INFORMATION

DATE_____

NAME_____ NICKNAME_____

ADDRESS_____
STREET APT# CITY STATE ZIP CODE

HOME PHONE (____) _____-_____ WORK PHONE (____) _____-_____

CELL PHONE (____) _____-_____ BIRTHDATE_____

SOC. SEC. # _____-_____-_____ AGE_____

EMPLOYER_____

WHO REFERRED YOU TO OUR OFFICE? _____

NAME OF YOUR GENERAL DENTIST_____

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INSURANCE AND PAYMENT INFORMATION

Insurance coverage is a contract between you and your insurance company. As a **COURTESY SERVICE** to you as a patient of ours we will assist you in filing your insurance claims. We will contact your insurance company via telephone/internet and request all pertinent information possible to determine an **ESTIMATE** of the out-of-pocket expenses you will incur from the proposed treatment plan. **THIS AMOUNT IS DUE IN FULL THE DAY OF SURGERY.**

****PLEASE REALIZE THIS AMOUNT IS AN ESTIMATE BASED UPON THE INFORMATION PROVIDED BY YOUR INSURANCE COMPANY. IT IS NOT A GUARANTEE OF BENEFITS. ANY DISCREPANCY WILL BECOME YOUR RESPONSIBILITY.** We will file your insurance claim for you and will do our best to cooperate with your insurance company to provide all information concerning your claim.

FOLLOWING PAYMENT BY YOUR INSURANCE COMPANY any remaining balance is your responsibility and payment is expected within 30 days of your notification by our office. If your insurance company does not pay in a timely fashion, you may need to settle the account yourself and seek reimbursement yourself from the insurance company.

IF YOU DO NOT HAVE INSURANCE COVERAGE FOR THE SERVICES PROVIDED, PAYMENT IS DUE IN FULL AT THE TIME SERVICES ARE RENDERED. Our staff can assist you in applying for financing through dental financing service companies if you wish.

PERSON RESPONSIBLE FOR PAYMENT FOR SERVICES RENDERED:

_____
Please Print

SIGNATURE: _____

DATE: _____ Ref_____ Ins. _____ M F

HEALTH HISTORY REVIEWED BY AND UPDATED BY PATIENT:

Date: _____/_____ _____/_____ _____/_____

Practice Limited to
Oral and Maxillofacial Surgery