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Waterman
Oral and Maxillofacial Surgery

PATIENT INFORMATION

(Please print clearly)

Date: _____ Referred by: _____

Patient's Name: First _____ M.I. ____ Last _____

Home Address _____ Apt. # _____ City _____

State _____ Zip _____ E-mail Address _____

Home Phone (_____) _____ -_____ Work Phone (_____) _____ -_____

Cell Phone (_____) _____ -_____ Date of Birth _____/_____/_____ Age _____

Social Security _____-_____-_____ Male_____ Female_____

Mailing Address (if different) _____

If College Student: Name, City and State of College _____

If patient is under 18, who do they live with? _____

Person responsible for paying for this account (other than the patient or insurance):

Name _____ Phone Number (_____) _____ -_____

Address _____ City _____ State _____ Zip _____

Social Security _____-_____-_____ Date of Birth _____/_____/_____

Relationship to Patient _____

Patient's without insurance are responsible for full payment on the day of service

****All paper work must be completed prior to seeing the doctor. There is a consultation fee*****

I hereby agree and authorize Dr. Nelson to render whatever services deemed necessary and agree to pay for such services. I understand that this office cannot render services on the assumption that the charges will be paid by my insurance company. I understand that I will be responsible for all charges or any amount not covered by my insurance. I further agree that if my account should become delinquent and is submitted to a collection agency or an attorney, that I will pay all reasonable attorney or collection fees including court costs and filing fees as allowed by law. I understand that there is a $75.00 charge for any broken appointments unless I give a **full 48 hour notice** of cancellation. I understand that any account balance will be charged an 18% APR. There is a $15.00 delinquent payment fee and a $25.00 return check charge.

PATIENT'S SIGNATURE: _____

(Parent or legal guardian to sign, if under 18)