The Center for Oral & Facial Surgery

William J. Wintersteen D.M.D., P.A.
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Print Form

PATIENT INFORMATION DATE:________________

Name Mr. ____
Mr. Miss. Ms. Mrs. Dr. First Middle Last Nickname

Circle: Male (●) Female ( ) Single ( ) Married ( ) E-mail____________________________

Address________________________City____________State________Zip____________

Home Phone________________ CellPhone________________WorkPhone________________

Employer________________________TDL#________________SS#________________

DOB____________ Age________ Emergency Contact____________________ Phone________________

***Referred by:________________ REASON FOR YOUR VISIT________________________

Person Responsible For Account

Father/Spouse

Name:____________________________
DOB:____________________________
SS#:____________________________
Employer:____________________________

Mother/Spouse

Name:____________________________
DOB:____________________________
SS#:____________________________
Employer:____________________________

Insurance Information:

Medical Insurance

Name of Insured:____________________________
Insurance Company:____________________________
Insurance Phone #:____________________________
ID #:________________ Group # :________________

Dental Insurance

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____
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ID #:________________ Group #:________________

****Please be sure all information is filled in and correct so that we may file a claim on your behalf. Please provide us with your medical and dental cards.**

**** Please initial that you have read and understand our HIPPA & Office Guidelines**____________

Financial Information

* Services are payable at the time they are rendered.
* As a convenience we will file a claim on your behalf. An insurance policy is a contract between the patient and insurance company. The patient or person responsible for the account will be responsible for any amount not paid by the insurance company within 6 weeks from the day the claim was filed. Any excess payment will be refunded immediately.
* There is a $25.00 non-sufficient funds fee for any returned check.
* There are fees associated with any records requiring duplication.

Print Form

SIGNATURE OF RESPONSIBLE PARTY: ________________________________