

J. Brian Murphy, D.D.S., P.A.
Implant & Oral Surgeon

TODAY'S DATE: ____ / ____ / ____

NAME: (Dr / Mr / Miss / Mrs / Ms) _____
(Please Circle) (First) (M.I.) (Last)

NICKNAME/PREFERRED NAME: _____

ADDRESS: _____
(Street) (City/State) (Zip)

ALTERNATE ADDRESS: _____
(Street) (City/State) (Zip)

HOME PHONE: (_____) _____ WORK PHONE:(_____) _____ EXT: _____

ALTERNATE PHONE: (_____) _____ FAX: (_____) _____

DATE OF BIRTH: _____ AGE: _____ MALE / FEMALE SOC. SEC. # _____
(Month Day Year) (Please Circle)

MARITAL STATUS: SINGLE MARRIED DIVORCED SEPARATED WIDOWED

OCCUPATION: _____

EMPLOYER NAME & ADDRESS: _____

REFERRED BY: _____ GENERAL DENTIST: _____

PHYSICIAN NAME & CITY _____ PHONE (_____) _____

Are you under the care of an additional physician for any reason? (Cardiologist/Hematologist, etc.) Yes No

If yes, please explain: _____

When was your last physical examination? _____ Was anything unusual or abnormal found?..... Yes No

If yes, please explain: _____

Have you ever had any operations, hospitalizations or serious illness?..... Yes No

If yes, please explain: _____

Have you been a patient in our office? _____ Has any member of your family been a patient in our office? _____

If yes, name _____

What is the name and location of your pharmacy ? _____

CONTINUED ON BACK

Implant & Oral Surgeon

FINANCIAL POLICY

As a courtesy and added benefits to our patients with insurance, we are more than happy to file your insurance for you. However, we do require you to pay the estimated percentage your insurance does not cover plus any deductible at the time of your appointment.

IF YOU HAVE INSURANCE PLEASE READ THIS IMPORTANT INFORMATION:

We will call your insurance company to verify your benefits and will review your treatment plan with you. Most insurance companies pay a percentage of what they consider to be usual and customary fee. Please understand that your insurance policy is not a "pay all", it is only assistance for you. You are ultimately responsible for all cost of your Surgical/Dental treatment. Your insurance company has a responsibility to you, NOT us; therefore it is your responsibility to pursue any payment issues with them. It is not our policy to contact your insurance carrier to establish why they have not paid or why they paid less than originally indicated. **As a Dental Office we do not file with Medical.** Please contact the insurance company immediately if there are any concerns. We will extend this credit for 60 days. After that our office requires you to pay the balance in full.

I _____, understand that I am ultimately responsible for all of the dental treatment.

PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT (IF OTHER THAN SELF)

NAME _____ RELATION TO PATIENT _____ DOB _____

ADDRESS _____

EMPLOYER _____

(NAME)

(ADDRESS/CITY/STATE)

HOME PHONE (____) _____ WORK PHONE (____) _____ SOC.SEC# _____

****I have read and understand the financial policy** _____

(PATIENT/GUARANTOR)

DATE

Name of Insurance Party _____ D.O.B. _____

S.S.# of Insured _____ Name Of Insurance Co. _____

Address _____ City/State, Zip _____

Insurance Co. Phone _____ Group No. _____

Insured's Employer _____

I hereby authorize release of any medical or other information necessary to process this claim.

I authorize payment of benefits otherwise payable to me directly to J. Brain Murphy D.D.S., P.A.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

INSURED SIGNATURE