RICHMOND
ORAL SURGERY ASSOCIATES
ACQ_LLC

Harry Papadopoulos, D.D.S., M.D. Date

PATIENT INFORMATION *(Please Print)*

Name:_____ Preferred Name:_____
First M.I. Last

Date of Birth_____ Gender: ( ) Male ( ) Female Age:_____ Soc. Sec. #_____/____/_____

Marital Status: ( ) Married ( ) Divorced ( ) Single ( ) Separated ( ) Widowed ( ) Partner

Address_____ City_____ State____ Zip_____

Cell Phone_____Alternate Phone_____Email_____

Employer_____ Work Phone#_____ Ext_____

Patient's Physician Name _____ Patient's Dentist Name _____

Who may we thank for referring you to our office? _____

FOR MINOR CHILDREN *(Under age of 18)*

Date of Birth: _____

Person Accompanying Patient to visit _____ Soc. Sec. #_____/____/_____
First M.I. Last

Address_____ City_____ State____ Zip_____

Relationship to patient_____ Phone# _____ Email _____

Place of Employment _____

Person who carries 1st Dental Insurance

Name _____ SS# _____/_____/_____

Date of Birth_____ Gender ( ) Male ( ) Female Relationship to patient _____

Address _____ City; _____ State: _____ Zip: _____

Cell Phone _____ Alt Phone_____ Employer: _____

Person who carries 2nd Dental Insurance

Name _____ SS# _____/_____/_____

Date of Birth_____ Gender ( ) Male ( ) Female Relationship to patient _____

Address _____ City; _____ State: _____ Zip: _____

Cell Phone _____ Alt Phone_____ Employer: _____

PLEASE COMPLETE THE REVERSE SIDE

PLEASE READ THIS ACKNOWLEDGEMENT AND AUTHORITY

I have completed this form fully and completely, and certify that I am the patient or the duly authorized agent of the patient furnishing the information requested.

* I have been offered a copy of the office Privacy Policy which is located in waiting room magazine rack. * I authorize Richmond Oral Surgery Associates LLC to release any information necessary to file a claim with my Insurance company. * **I am responsible for payment for treatment performed by Dr. Papadopoulos regardless of any insurance coverage or other circumstances when services are rendered.** * I also understand that I will be billed for any unpaid balance and that payment in full is due within 60 days from the date of treatment. * If my account is turned over for collection, I understand that additional collection and/or court costs including reasonable attorney fees will be added to the account balance. * There will be a $35.00 charge for all returned checks.

Signature of Patient or Guardian X_____ Date _____

HIPPA RELEASE *Please provide name(s) of individuals we may talk with concerning your healhcare*

Name _____ Relationship _____ Phone#_____

Name _____ Relationship _____ Phone#_____

_____None. Do not release information to anyone