ORAL AND FACIAL SURGERY CENTER

ROBIN C. ARDOIN, D.D.S., PH.D.
HAROLD D. KENNEDY, D.D.S.

Referred by: _____ Date:_____

Patient: _____ , _____, _____ (_____)
Last Name First Name Middle Initial Nickname

Address:_____
Street City State Zip

Mailing Address: _____
Street City State Zip

Home Phone:_____ Sex ❑ M ❑ F Date of Birth: _____ Age:_____

SS #:_____ Place of Employment: _____ Work Phone: _____

Parent if Minor: _____ Cell Phone :_____

Work Phone: _____

In case of an emergency, contact: _____

Relationship: _____

Telephone #: _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT?

Responsible Party: _____, _____ , _____
Last Name First Name Middle Initial

Address if different from patient's address: _____

Home Phone: _____ Sex ❑ M ❑ F Date of Birth: _____Age: ____

Place of Employment: _____ Work Phone: _____

S.S.# : _____ Cell Phone: _____

FINANCIAL RESPONSIBILITY AGREEMENT

It is the policy of this office to require full payment for your office exam and x-rays (if required) at the time of the exam. I understand that even though I may have some type of insurance coverage, I am fully responsible for payment of services rendered.

I HAVE READ THE PAYMENT OPTIONS ON THE LAST PAGE OF THESE FORMS AND FULLY UNDERSTAND THEM.

Date: _____ Signature of Responsible Party: X _____