WALTER MICHAJLENKO DDS, MD
ORAL & MAXILLOFACIAL SURGERY

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you.

PATIENT INFORMATION

Patient's Name (Mr./Mrs./Ms./Dr.) _____
(Last) (First) (MI)
I prefer to be called _____ Date _____ Social Sec. # _____
Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Minor ☐ Age _____ Birthdate _____
Medical Doctor _____ Dentist _____ Referred to this office by _____
Home Address _____ City _____ State _____ Zip _____
Home Phone _____ Business Phone _____ Driver's License # _____
Have you ever been a patient of our practice? Yes ☐ No ☐ Method of payment: Cash ☐ Check ☐ Credit Card ☐

Patient employed by _____ Position/Occupation _____
Business Address _____ City _____ State _____ Zip _____
Spouse/Parent Name (circle one) _____ Social Sec. # _____
(Last) (First) (MI)
Spouse/Parent Employed by (circle one) _____ Position/Occupation _____
Business Address _____ Business Phone _____

Person responsible for account _____
(Last) (First) (MI)
Relationship to patient _____ Birthdate _____ Social Sec. # _____
Address (if different than patient) _____ City _____ State _____ Zip _____
Home Phone _____ Business Phone _____ Driver's License# _____
Person responsible employed by _____ Position/Occupation _____
Business Address _____ City _____ State _____ Zip _____
Relative not living with you _____ Address & Phone _____

PRIMARY DENTAL INSURANCE

Insured Party _____
(Last) (First) (MI)
Relationship to patient _____ Birthdate _____ Social Sec. # _____
Address (if different than patient) _____ City _____ State _____ Zip _____
Home Phone _____ Business Phone _____ Driver's License # _____
Person responsible employed by _____ Position Occupation _____
Business Address _____ City _____ State _____ Zip _____
Insurance Company _____ Address _____ Phone _____
Plan/ID # _____ Group # _____ Subscriber # _____
Are you a student? No ☐ Full-Time ☐ Part-Time ☐ School Name/Address _____
Is patient covered by additional dental insurance? Yes ☐ No ☐ If so, please complete the next section.

SECONDARY DENTAL INSURANCE

Insured Party _____
(Last) (First) (MI)
Relationship to patient _____ Birthdate _____ Social Sec. # _____
Address (if different than patient) _____ City _____ State _____ Zip _____

PLEASE COMPLETE BOTH SIDES

Home Phone _____ Business Phone _____ Driver's License # _____
Person responsible employed by _____ Position/Occupation _____
Business Address _____ City _____ State _____ Zip _____
Insurance Company _____ Address _____ Phone _____
Plan/ID # _____ Group # _____ Subscriber # _____

Primary Medical Insurance

Insured Party _____
Relationship to patient _____ Birthdate _____ Social Sec. # _____
Address (if different than patient) _____ City _____ State _____ Zip _____
Home Phone _____ Business Phone _____ Driver's License # _____
Person responsible employed by _____ Position/Occupation _____
Business Address _____ City _____ State _____ Zip _____
Insurance Company _____ Address _____ Phone _____
Plan/ID # _____ Group # _____ Subscriber # _____
Are you a student? No ☐ Full-Time ☐ Part-Time ☐ School Name/Address _____
Is patient covered by additional medical insurance? Yes ☐ No ☐ If so, please complete the next section.

Fees and Payments

We make every effort to keep down the cost of your oral surgical care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductive amount, co-insurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorneys fees and court costs.

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to Walter Michajlenko, DDS, MD of the benefits other wise payable to me.

Patient/Guardian's Signature _____ Date _____