Registration Form

Armitage Oral Surgery
Oral & Maxillofacial Surgery

Today's Date:

Patient Information

Patient's Name:		Legal guardian, if patient is a minor:	
Street Address	City	State	Zip Code
Birth date: Sex: ☐ Male ☐ Female	**Social Security number:**		
Reason for your visit today, be specific:			
Occupation:	**Employer/Address**:		**Employer Phone:**
Patient's Dentist Name Address:		Phone	

Contact Information

Home Phone: Cell Phone: Work Phone: Email:	Emergency Contact Name: Phone: Relationship:

I authorize Dr. Katabi or a member of his staff to discuss any Protected Health Information with:
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

Referred to Armitage Oral Surgery by:
☐ Dr. _____ ☐ Other _____

INSURANCE INFORMATION

Please give your insurance cards to the receptionist

Patient covered by insurance: ☐ Yes ☐ No fgdhjgfjltjljtllj

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Subscriber's Name:	Subscriber's Address	Subscriber phone: ( )
Subscriber's Birth date:	Name of Primary Insurance:	Subscriber's SSN:
Policy no./ID:	Group #:	Subscriber's Employer:

Form of Payment for today's Procedure: ☐ **Cash** ☐ **Check** ☐ **Credit Card** ☐ **Care Credit**

IMPORTANT INFORMATION -- PLEASE READ CAREFULLY:

- I understand **all fees are the responsibility of the patient or responsible adult (if patient is a minor)** ***regardless of insurance claims or other benefits.***
- I understand that Dr. Katabi are not Medicare providers, ***therefore, Medicare will not be billed.*** If you wish to use your Medicare benefits, you can choose to see a Medicare provider.
- If, after 60 days, my insurance company has not paid **I understand I am still responsible for the bill** and will incur the monthly finance charge of 1.5% (18% annual) on ***any*** **unpaid balance after 60 days, even if insurance has not paid their portion.**
- I authorize the release of any medical or other information necessary to process this claim.
- I hereby authorize insurance payments directly to the doctor of benefit for his services provided to me.
- I give permission to contact any of the phone numbers provided by myself.
- I understand **no pictures or video** will be allowed by anyone other than office staff.

Signature: **Date:**

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