Vincent Frey, D.M.D. and Dr. Meredith Blitz D.D.S.
Practice limited to ORAL AND MAXILLOFACIAL SURGERY

PATIENT NAME: (Mr. Mrs. Ms. Dr.) Today's Date: _____

First Name:_____ Middle Initial:____Last Name:_____
Date of Birth:_____ Age:____Social Security No.: _____ Sex: _Male _Female
Address: _____
City:_____ State:_____Zip Code:_____
Home Telephone: ( ) _____Work Phone: ( ) _____Cell Phone: (___)_____
Dentist:_____ Physician: _____Referred by: _____
Parent Name (if patient is minor or dependent): _____ Social Security #_____

INSURANCE INFORMATION

MEDICAL Insurance Co._____ID No.:_____
Employer Name: _____ Group No: _____
Subscriber: Name_____Social Sec. No.:_____ Date of Birth:_____
Patient Relationship to Subscriber: _____

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DENTAL Insurance Co._____ID No.:_____
Employer Name: _____ Group No: _____
Subscriber: Name_____Social Sec. No: _____Date of Birth: _____
Patient Relationship to Subscriber:_____

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2ndMEDICAL Insurance Co._____ID No._____
Employer Name: _____ Group No: _____
Subscriber: Name_____ Social Sec. No.: _____ Date of Birth: _____
Patient Relationship to Subscriber: _____

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2ndDENTAL Insurance Co._____ID.No._____
Employer Name: _____ Group No: _____
Subscriber: Name_____Social Sec. No: _____Date of Birth: _____
Patient Relationship to Subscriber:_____

Release of Medical Information and Assignment of Benefits

I authorize the release of any medical and dental information necessary to process this claim to my insurance carrier for services rendered by the provider and direct my insurance company to issue payment to this office. I understand that I am ultimately financially responsible for any services provided by this office. If benefits are assigned and I receive a check from my insurance company, I am liable to forward the check to the provider of services within ten (10) business days of receiving the check pursuant to Act A.1897/S.1409 or face fines and /or jail time. If my insurance company does not pay the claim within eight (8) weeks, I am responsible to pay any outstanding balanced to the provider's office. Any balance outstanding for over 60 days will be subject to a finance charge of 1.5% monthly. If the balance is forwarded to a collection agency, a 33 1/3% collections fee will be added on.

Signature:_____ **Date** _____