ROLF B. WOLFROM, DDS, PA
ORAL AND MAXILLOFACIAL SURGERY
OF THE PALM BEACHES

Patient's Name: _____ Date: _____

Sex: _____ Age: _____ Birth Date: _____ Soc. Sec.# _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Patient's Email _____

Spouses' Name/Responsible Party: _____

Spouses' Employer: _____ Phone: _____

Name of Insurance: _____ Group Number: _____

Insured's I.D. number: _____ Soc. Sec.# _____

Insured's Date of Birth: _____ Relationship to Insured: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____

Insured's Employer: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact Name & Phone Number _____

PATIENT'S FINANCIAL OBLIGATION

No insurance coverage: payment is due in full, at the time of the visit.

Primary Insurance Coverage: patient's portion must be paid at the time of the visit.

As a courtesy to our patients our office will submit to your primary insurance only. Any remaining balance will be due in 60 days, regardless of pending insurance.

For delinquent accounts, patients will be responsible for all costs including collection fees, court cost and a $25.00 preparation fee and reasonable attorney fees, will be insured by the signing party. I understand that if my account is turned over to collection - my personal information will be provided.

I fully agree that I am personally responsible for any financial obligation pursuant to signing this agreement.

_____ _____ _____

PATIENT/GUARDIAN SIGNATURE **DATE** **WITNESS**

SUBMIT