Dr. Tyler E. Nelson DMD MD
Oral & Maxillofacial Surgery

PATIENT INFORMATION

(Please print clearly)

Date: ______________________ Referred by: ___________________

Patient's Name: First _________________________ M.I. ____ Last ____________________________

Home Address ______________________________ Apt. # _______ City _______________________

State ___________ Zip _______________ E-mail Address ________________________________

Home Phone (_______) ________ -____________ Work Phone (_______) ________ -____________

Cell Phone (_______) ________ -____________ Date of Birth _____/_____/_____ Age ________

Social Security ___________-_______-_____________ Male_____ Female_____

Mailing Address (if different) ____

If College Student: Name, City and State of College ____

If patient is under 18, who do they live with? ____

Person responsible for paying for this account (other than the patient or insurance):

Name __________________________________ Phone Number (_______) ________ -____________

Address ______________________________ City ________________ State ____________ Zip ________

Social Security ___________-_______-_____________ Date of Birth _____/_____/_____

Relationship to Patient _____________________________________

Patient's without insurance are responsible for full payment on the day of service

*****All paper work must be completed prior to seeing the doctor. There is a consultation fee*****

I hereby agree and authorize Dr. Nelson or Dr. Saunderson to render whatever services deemed necessary and agree to pay for such services. I understand that this office cannot render services on the assumption that the charges will be paid by my insurance company. I understand that I will be responsible for all charges or any amount not covered by my insurance. I further agree that if my account should become delinquent and is submitted to a collection agency or an attorney, that I will pay all reasonable attorney or collection fees including court costs and filing fees as allowed by law. I understand that there is a $75.00 charge for any broken appointments unless I give a **full 24 hour notice** of cancellation. I understand that any account balance will be charged an 18% APR. There is a $15.00 delinquent payment fee and a $25.00 return check charge.

PATIENT'S SIGNATURE: ____

(Parent or legal guardian to sign, if under 18)