Michael B. Kushner DDS LLC

Oral and Maxillofacial Surgery

Patient Information:

Name: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Social Security Number: _____ Birthday: _____ Age: _____

Purpose of Appointment: _____

Referred By: _____

Responsible Party: *Who is responsible for the account?*

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Employed By: _____

Business Address: _____

Spouse Employed By: _____

Business Address: _____

Home Phone: _____ Work Phone: _____

Social Security Number: _____ Birthday: _____

Relationship to Patient: _____ Marital Status: _____

Driver's License #: _____

Financial Policy

Payment is due in full at each appointment. If an insurance predetermination has been received, the co-pay is due in full at each appointment. Any amounts outstanding after insurance payment will be billed to the patient.

Late Charges

If I do not pay the entire balance within 60 days, a late charge of 1.5% on the balance will be assessed each month. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding balance.

_____

Signature of responsible party Relationship Date