DARRIN J. VIOLI, D.M.D., P.S.C.
Oral & Maxillofacial Surgeon

Referring Doctor:_____
Today's Date:_____

Patients Last Name:_____First Name:_____ M.I_____ SEX: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Widowed ☐ Single ☐ Minor **DOB**:_____ Age:_____
If minor, a parent is required to accompany minor to visit and complete any and all forms.

Mailing Address:_____
City State Zip
Patients Social Sec. #:_____Home Phone: ( ) _____Cell Phone: ( ) _____

Email Address:_____

Patient Employer:_____ Work #:( ) _____

Emergency Contact:_____ Phone #:( ) _____
NOTE: You MUST put any person listed above on your HIPAA form or we will not be able to discuss any information with them.

Dental Insurance
Insurance Co._____
Insurance Co. Phone #_____
Primary Cardholder_____
Cardholders Employer_____
Cardholders DOB_____
Relationship to Pt._____
Cardholders SS #_____

Medical Insurance
Insurance Co._____
Insurance Co. Phone #_____
Primary Cardholder_____
Cardholders Employer_____
Cardholders DOB_____
Relationship to Pt._____
Cardholders SS #_____

Do you have secondary insurance?_____If yes, please write the info for that insurance on the back with all subscriber info.

WE REQUIRE A COPY OF YOUR INSURANCE CARDS AND A PHOTO ID

AUTHORIZATION

I hereby authorize Darrin J. Violi, D.M.D., to release any medical information necessary to process my insurance claims. I authorize and assign payment directly to Darrin J. Violi, D.M.D., of any such benefits otherwise payable to me as determined by the insurance company on account of expenses for the indicated services. I am allowing Darrin J. Violi, D.M.D. or any billing agency affiliated with this office to call my home, cell phone, text me, or email me, by use of an auto-dialer regarding any financial matters.

If we participate with your insurance plan, we will gladly file your claim for you; however any charges not covered by your insurance are your responsibility and must be paid at time of service, as we do not do any type of payment plans. If you would like to finance your payment we do offer Care Credit for applicants that are approved. Any balance left on your account after insurance is filed is due upon receipt of billing statement. If this matter is not remedied by the next billing cycle, your account will be turned over to collections. Please note, you must give this office a minimum of 24 hours notice of cancellation for any upcoming appointments, or you will be charged a no-show fee which will reflect a minimum of 10% of your scheduled surgery.

Most insurance companies do not pay 100% of fees charged. Payment is expected at the time service is rendered.

How would you like to pay for today's visit? (Circle one- required) CASH CHECK CREDIT CARD CARE CREDIT

SIGNATURE:_____ DATE:_____