STEVEN R. SCHWARTZ, DDS
NY Oral & Maxillofacial Surgeon, P.C.

Patient Contact/ Financial and Insurance Information (Please Print)

Patient Social Security #_____ Spouse/Parent Social Security #_____

Who is responsible for this account?_____ Relationship to Patient_____

Patient Employed By _____Occupation _____

Business Address_____ Business Phone_____

Spouse/Parent Name_____ Spouse/Parent Birthdate_____

Spouse/Parent Employed By_____ Email Address_____

Business Address_____ Business Phone_____

Name of Primary Dental Insurance Company_____ Group Number_____

Name of Primary Medical Insurance Company_____ Group Number_____

Primary Insured Name_____ Insured's Birthdate_____

Insured Employed By_____ Occupation_____

Business Address_____ Business/Cell Phone_____

Secondary Insured Name_____ Insured's Birthdate_____

Insured Employed By_____ Occupation_____

Business Address_____ Business/Cell Phone_____

In case of emergency, who should be notified?_____ Relation_____

Contact's Address_____ Contact's Phone Numbers_____

FINANCIAL POLICY: Full payment is expected on the day of surgery or consultation. We offer the following payment options. Please place a checkmark beside the option(s) you wish to use.

❑ Cash ❑ Personal Check ❑ VISA/MC/DISC/AMEX ❑ Debit Card ❑ Springstone/ Citibank

On your statement, amounts owed by you (not covered by insurance) are listed as amounts due. A 1.5% (APR18%) finance charge is applied to any amount due carried beyond 30 days. The minimum monthly finance charge is $5.00.

I agree, that in the event any amount due for services rendered from the date of billing are referred to an agency or attorney for collection, I shall be responsible for and pay any and all costs associated with such collection costs including court costs and reasonable attorneys' fees in such amounts as may be fixed by the court plus interest. All amounts remaining unpaid following thirty (30) days from the date of billing shall accrue interest at the highest statutory rate from and after the date of billing.

INSURANCE POLICY: No insurance company will cover 100% of all dental/medical expenses. We can only estimate insurance payments. We do our best to collect from insurance carriers on your behalf, but you are responsible for the unpaid balance. Should your insurance company pay more than we estimate, we will send you a refund. If your insurance company pays less than we estimate, we will send you an itemized bill. Insurance coverage is not a reliable indication of the most appropriate treatment. This is a matter best decided between you and the doctor.

I agree that all dental and medical insurance policies are an arrangement between an insurance carrier and myself. I clearly understand that all services rendered to me are charged directly to me and that I am personally responsible for payment, regardless of my insurance company's determination.

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold Dr. Steven R. Schwartz or any member of his staff responsible for any errors or omissions that I have made in the completion of this form.

Please sign below to indicate that you understand and accept the above information and policies.

_____ _____

Signature Date