Waterman
Oral and Maxillofacial Surgery

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# Patient Information

Date: ______________________ Referred by: ________________________________

Patient Name: First ____________________M.I. ____ Last __________________________Date of Birth__________

Social Security ___________-_______-_____________ Male ☐ Female ☐

Home Address ____________________________Apt. # ______ City _____________State ___Zip _____________

Home Phone (____) _____________ Work Phone (___) _____________Cell Phone (_______) _________________

E-mail Address ___________________________________________________________________________________

Mailing Address (if different) _____________________________________________________________________

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

**In case of emergency**

Name __________________________________ __Relationship ______________________________________________

Phone Number_____________________________________

*****There is a consultation fee*****

I understand 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 cost and filing fees as allowed by law. I understand that there is a $175.00 charge for any broken appointments unless I give a full 48 hour business notice of cancellation. I understand that any account balance will be charged an 18% APR. There is a $25.00 delinquent payment fee and a $25.00 return check charge.

**Patient signature:** _____________________________________________________________________________

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