



HUGH P. BRINDLEY, D.M.D., P.A.
 PRACTICE LIMITED TO
 ORAL AND MAXILLOFACIAL SURGERY

48 Medical Park East Drive, Suite 158
 Birmingham, Alabama 35235
 (205) 838-3060

103 2nd Avenue N.E.
 Cullman, Alabama 35055
 (256) 734-4655

PATIENT INFORMATION SHEET

TODAY'S DATE: _____

(PLEASE PRINT)

PATIENT'S NAME _____
ADDRESS _____
CITY _____ **STATE** _____ **ZIP CODE** _____
SOC. SEC. # _____ **HOME PHONE** _____ **WORK PHONE** _____ **CELL** _____
AGE _____ **BIRTHDATE (M/D/Y)** _____ **MARITAL STATUS** _____ **SEX: M F**
EMPLOYED BY _____

DENTIST _____ **PHYSICIAN** _____
REFERRED BY: _____

PERSON RESPONSIBLE FOR ACCOUNT: _____
 (If different from patient - relationship to patient) _____
ADDRESS _____
CITY _____ **STATE** _____ **ZIP CODE** _____
SOC. SEC. # _____ **HOME PHONE** _____ **WORK PHONE** _____ **CELL** _____
EMPLOYED BY _____

DENTAL INSURANCE _____
ADDRESS _____
CITY _____ **STATE** _____ **ZIP CODE** _____
NAME IN WHICH THE INSURANCE IS LISTED _____ **D.O.B.** _____
ID#/SS# _____ **GROUP #** _____
EMPLOYER: _____ **EMPLOYER PHONE:** _____

MEDICAL INSURANCE _____
ADDRESS _____
CITY _____ **STATE** _____ **ZIP CODE** _____
NAME IN WHICH THE INSURANCE IS LISTED _____ **D.O.B.** _____
ID#/SS# _____ **GROUP #** _____
EMPLOYER: _____ **EMPLOYER PHONE:** _____

We will file insurance at no extra charge; however, responsibility for the account remains with you, the patient, or responsible party. If insurance is filed, we MUST have all the correct insurance information on the date the initial service is rendered. It is your responsibility to make sure we have accurate insurance information to file the claim correctly. If the insurance company does not pay Dr. Hugh P. Brindley within 60 days of the date of service, the undersigned will be responsible for making payment in its entirety. There may be a fee for any additional filing to your insurance other than the initial claim filed for the date of service. (Insurance claims are filed 1-7 days after the date of service.)

The undersigned hereby agrees to pay all costs of collection including reasonable attorney fees, in the event the debt is turned over for collection. PLEASE NOTE: THERE WILL BE A \$35 CHARGE ON ALL RETURNED CHECKS AND THERE WILL BE FINANCE CHARGES ON ALL PAST DUE ACCOUNTS BEYOND 60 DAYS FROM THE DATE OF SERVICE IN THE AMOUNT OF 1% MONTHLY OR 12% ANNUALLY.

SIGNATURE **X** _____

I HEREBY AUTHORIZE RELEASE OF ANY MEDICAL RECORDS AND PAYMENT FROM INSURANCE COMPANY DIRECTLY TO HUGH P. BRINDLEY, D.M.D., P.A.

SIGNATURE: **X** _____

PATIENT CONTACT SHEET

The person(s) listed below may be contacted in reference to my medical/dental care and/or in case of a medical/dental emergency.

Name: _____ Relationship: _____

Phone # _____

Name: _____ Relationship: _____

Phone # _____

Name: _____ Relationship: _____

Phone # _____

Name: _____ Relationship: _____

Phone # _____