Center For Oral & Maxillofacial Surgery

ASIF TAUFIQ, D.D.S., M.B.A.
Diplomate American Board of Oral & Maxillofacial Surgery

3619 Braselton Hwy Ste. 101
Dacula, GA 30019
PH (770) 831-6602
FAX (770) 831-6608

15 Collins Industrial Way Ste.B
Lawrenceville, GA 30043
PH (770) 962-0515
FAX (770) 962-1244

CONFIDENTIAL

PLEASE FILL OUT COMPLETELY

PATIENT INFORMATION DATE:_____20_____

Have you ever visited our office before? ☐ Yes ☐ No If yes, which location:_____
First Name:_____M.I.:_____Last:_____
Address:_____Apt/Lot#:_____
City:_____State:_____Zip Code:_____Sex: ☐ M ☐ F
Hm Ph#: ( )_____Cell Ph#: ( )_____
Soc Sec #:_____DOB:_____Age:_____
Employer:_____Wk Ph#:( )_____
Address:_____Suite:_____
City:_____State:_____Zip Code:_____Occupation:_____
Martial Status:_____Spouse Name:_____Cell Ph#:_____
Nearest relative **NOT** living with you:_____Relationship:_____
Address:_____Apt/Lot#:_____
City:_____State:_____Zip Code:_____Hm Ph#:_____
Are you a student? ☐ Yes ☐ No E-mail:_____
If yes, Name of school?_____
Who can we thank for referring you here today?_____

RESPONSIBLE PARTY INFORMATION

Who will be responsible for your account? ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other:_____
(If self pay, skip to next section)
First Name:_____M.I.:_____Last:_____Relationship:_____
Address:_____Apt/Lot#:_____
City:_____ State:_____Zip Code:_____Ph#: ( )_____
Soc Sec#:_____ DOB:_____Age:_____
Employer:_____Occupation:_____
Address:_____Suite #:_____
City: State: Zip Code: Wk Ph #:( )

INSURANCE INFORMATION

Name of Insurance Co:_____
Insurance Ph#:_____ID#:_____Group#_____
Name of policy holder:_____Soc Sec#:_____
DOB:_____Relationship to pt:_____

TURN OVER

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ASSIGNMENT AND RELEASE

I, undersigned Certify that I (or my dependent) have insurance coverage with_____ and assign directly to Dr. Taufiq, or any of the associates, all insurance benefits if any, otherwise payable to me for services rendered. I also understand that I am ultimately responsible for my account, so if any charges are not covered by my insurance I must pay them immediately thereafter. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on insurance submissions.

Responsible Party Signature:_____

Relationship to Patient:_____Date:_____

MINOR/CHILD CONSENT

I, being the parent of _____do hereby request and authorize the dental staff to perform necessary dental services for my child, including, but not limited to, x-rays and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Signature of Parent/Guardian:_____Date:_____

FOR ALL PATIENTS

I acknowledge that payment is due at the time of treatment. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor /child. I accept full responsibility for all charges not covered by my insurance.

Signature of Patient/Guardian_____Date:_____

IMPORTANT INFORMATION FOR NEW PATIENTS

Our office policy requires all healthcare staff to obtain, verify and record information that identifies each new patient. This policy is for your protection. Identity thieves use people's identifying information to request health care services. This misuse of your information may result in declined healthcare coverage or financial responsibility for services not rendered to you. When you visit our office we will ask for your name, address, date of birth, and other information that will allow us to indentify you .Our office will obtain, verify and record the following information, Name, Address, Date of birth, Social Security Number, Insurance ID and other supporting documentation. We will also request that you allow us to take a digital photo of you for our records and your protection.

Signature of Patient/Guardian:_____Date:_____

NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have read and fully understand the Privacy Practices of Center for Oral & Maxillofacial Surgery/ Hamilton Mill Center for Oral & Maxillofacial Surgery.

Signature of Patient/Guardian:_____

Printed Name:_____Date:_____