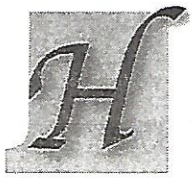
Dr. Joseph M. Hildebrand, DDS
50154 Schoenherr Road
Shelby Twp., MI 48315

P: (586) 731-9050
F: (586) 731-9056



JOSEPH M. HILDEBRAND, D.D.S., P.C.
ORAL AND MAXILLOFACIAL SURGERY

Diplomate, American Board of Oral and Maxillofacial Surgery

www.drjhildebrand.com

Patient Registration

Patient Name:_____ Marital Status:_____ Male__ Female__

DOB___/___/_____ Age___ SSN#_____ Employer _____

Home Address:_____ City/State:_____ Zip:_____

Home Phone: ( )_____ Business Phone: ( )_____

Student: Yes__ No__ Full Time__ Part Time__ Name of School:_____ Location:_____

Spouse's Name:_____ DOB___/___/_____ SSN#_____ Employer _____

Insurance Information

Name of **Primary Dental** Insurance:_____ Subscriber: _____

Name of **Secondary Dental** Insurance:_____ Subscriber: _____

Name of **Primary Medical** Insurance:_____ Subscriber: _____

Name of **Secondary Medical** Insurance:_____ Subscriber: _____

Have you had a full mouth set of x-rays or a panorex within the past three (3) years?_____ Where? _____

Name of General Dentist:_____ Name of Primary Care Physician/General Doctor:_____

Who may we thank for referring you to our practice?_____

FILL IN THIS PORTION ONLY IF PATIENT IS COVERED BY ***PARENT(S) INSURANCE* OR IS A ***MINOR****

Father's Name:_____ SSN#_____ DOB___/___/_____

Father's Address:_____ City/State:_____ Zip:_____

Father's Employer_____ Business Phone Number: ( )_____

Mother's Name:_____ SSN#_____ DOB___/___/_____

Mother's Address:_____ City/State:_____ Zip:_____

Mother's Employer_____ Business Phone Number: ( )_____

FEES AND PAYMENTS

We make every effort to keep down the cost of your oral surgical care. An estimate of the charge for any procedure or surgery you may require will be given to you upon request.

If you have any dental and/or medical insurance, we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge.

It s your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorney's fees, and court costs.

Signature:_____ Date:_____