Raj S. Guraya, DDS, MD
Oral and Maxillofacial Surgery
1922 Thomson Drive, Lynchburg, VA 24502

Patient Information Section:

Patient's Full Name _____ Social Sec#: _____

Mailing Address: _____Street Address: _____

City: _____ State: _____ Zip: _____ Home Ph: _____

Cell Phone of Patient: _____ Email: _____

Date of Birth: _____ Marital Status: _____ Patient Employer: _____

Patient's Family Dentist: _____ Patient's Family Physician: _____

Parent Information (if under 18) or Spouse Information if Married:

Name of Spouse or Parent:_____ Cell: _____

Employer of Spouse or Parent: _____ Work Ph#_____

Address of Spouse or Parent: _____

Emergency Contact Info:

Emergency Contact Name and Number: _____

Billing Information:

Name of Person Responsible for the bill: _____

Responsible Person's Billing Address: _____

City: _____ State: _____ Zip: _____ Daytime Ph: _____

Date of Birth: _____ Social Security Number: _____

Place of Work: _____ Work Phone # _____

Medical Insurance Subscriber Info: (The completion of this section does not require card or ID# and is about the person who has the insurance in their name and MUST be completed)
(Please Circle YES OR NO to indicate if you have Medicare as your medical insurance.

Primary Medical Insurance Company: _____Name of Policy Holder: _____

Date of Birth: _____ Social Security Number: _____

Name of Employer: _____ Insured's Relationship to Patient: _____

Secondary Medical Insurance Company: _____Name of Policy Holder: _____

Date of Birth: _____ Social Security Number: _____

Name of Employer: _____ Insured's Relationship to Patient: _____

Dental Insurance Information:

Primary Dental Insurance Company: _____Name of Policy Holder: _____

Date of Birth: _____ Social Security Number: _____

Name of Employer: _____ Insured's Relationship to Patient: _____

Secondary Dental Insurance Company: _____Name of Policy Holder: _____

Date of Birth: _____ Social Security Number: _____

Name of Employer: _____ Insured's Relationship to Patient: _____

FAILURE TO SHOW FOR AN SCHEDULED SURGERY APPOINTMENT WITHOUT A 24 HOURS NOTICE, WILL RESULT IN THE ASSESSMENT OF $50.00 FEE. THIS CHARGE IS YOUR RESPONSIBILITY, AND IS NOT COVERED BY YOUR INSURANCE CARRIER.

To help eliminate billing costs, all fees are due at the time of treatment unless other arrangements have been made BEFORE today's appointment. Any remaining balances after insurance are the responsibility of the patient/guarantor. Past due account balances will be charged interest at the rate of 1.5% monthly (18% APR). If my account becomes assigned to a collection agency, I agree to pay all collection agency fees, court costs and attorney fees. I agree that is authorization shall be valid until rescinded in writing or replaced by an update agreement.

Signature of Patient, if 18 or over: _____

Signature of Person Responsible for the Bill for patient under 18: _____

Date: _____ of Signature(s)