The Center For Jaw And Facial Surgery, P.C.
901 Medical Park Drive, Suite 200
Effingham, Il 62401

SIGNATURE ON FILE

The information I have given is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance benefits for which I am entitled. I will not hold my physician or any member of his/her staff responsible for any errors or omissions that I have made in the completion of these forms. I authorize use of this form on all my insurance submissions and release of information to all my insurance companies. I authorize payment directly to my doctor unless payment has been made by me. I understand responsibility for payment is mine and is payable at the time services are rendered. I further understand all attorney fees, court costs, and collection service fees incurred in the collection of this account are my responsibility. I permit a copy of this authorization to be used in place of the original.

Name: _____

Signature: _____ Date: _____

PATIENT QUESTIONNAIRE

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, appointments, payment, labs, test results and healthcare operations):

Name	Relationship	Phone #
Name	Relationship	Phone #
Name	Relationship	Phone #

Please list the family members or other persons, if any, whom we may inform about your medical condition, ONLY IN AN EMERGENCY:

Name	Relationship	Phone #
Name	Relationship	Phone #
Name	Relationship	Phone #

Initial & date if no changes: _____/_____ Initials / date _____/_____ Initials / date _____/_____ Initials / date _____/_____ Initials / date