WELCOME

Thank you for selecting our oral surgical team! We strive to provide you with the best possible care. To help us meet all your surgical health care needs, please fill out this form completely. If you need any assistance or have any questions, please ask our friendly staff – we will be happy to help.

PATIENT INFORMATION

Email (to confirm appts): ______________________________

First Name____________________ Last Name__________________________ Middle Initial____ Phone ________________

Social Security Number ______________________________ Male Female Cell Phone ________________

Minor Single Married Widowed **Birth Date**____________________ Age ______

Address ____ City, State, Zip ______________________________

Employer______________________________ Occupation_________________________ Work Phone ________________

In event of an emergency, whom should we contact? Name ___________________ Relationship ____ Phone ________________

(PARENT/ LEGAL GUARDIAN ACCOMPANYING MINOR)

First Name ______________________ Last Name____________________________ Relationship to Patient__________

Birth Date ___________ Social Security Number_________________________________ Home Phone ________________

Address ____ City, State, Zip ______________________________

Employer______________________________________ Work Phone__________________ Cell Phone ________________

(THE FOLLOWING INFORMATION IS REQUIRED TO BILL YOUR INSURANCE)

PRIMARY INSURANCE

Name of Insured ________________________________

Relationship to Patient ____________________________

Address ______________________________________

(if different from Patient)

Insured's Birth Date________ Employer ________________

Social Security # ___________________________________

Insurance Company__________________________________

Insurance Address__________________________________

Group #________________ ID# ____________________

SECONDARY INSURANCE

Name of Insured____________________________________

Relationship to Patient ______________________________

Address ______________________________________

(if different from Patient)

Insured's Birth Date________ Employer________________

Social Security # ___________________________________

Insurance Company__________________________________

Insurance Address __________________________________

Group #________________ ID# ____________________

With the exception of your insurance and treating physicians, HIPAA restricts us from disclosing information to ANYONE without your written consent. If you wish to authorize release of information to someone (parent, spouse, friend etc...) please let us know:

____ ____

Name Relationship Name Relationship

I authorize and request my insurance company to pay directly to the dentist otherwise payable by me. I understand that my dental insurance carrier may pay less then the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. You have my permission to contact me via cell phone to discuss any matters related to my account or that of my dependents.

Signature of patient or responsible party **X**____ Date ______________

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