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 and we will be happy to help.

***We will ONLY use your email address for a post-treatment feedback form.**

PATIENT INFORMATION

Email (for feedback): ______________________________

First Name______________________ Last Name__________________________ Middle Initial______

Social Security Number ______________________________ Age _________ Birthdate ______________

Phone: ______________ Cell Phone ________________ Phone Carrier (Appt reminders) ______________

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 DENTAL 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 DENTAL 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 ______________