

PATIENT INFORMATION (PLEASE PRINT)

(Mr., Mrs., Ms.) _____ Patient Name _____ Sex: M F
Mailing Address _____ City _____ State _____ Zip _____
Phone Numbers Home _____ Business _____ Cell _____
Date of Birth _____ Age _____ Social Security # _____
Dentist _____ Orthodontist _____ Physician _____ Referred By _____
Occupation _____ Place of Employment _____
Spouse _____ Social Security # _____
Address _____ Employer _____
Emergency Contact Name and Phone _____

INSURANCE INFORMATION

Medical Insurance _____ Dental Insurance _____
Subscriber Name _____ Subscriber Name _____
SS# _____ SS# _____
Date of Birth _____ Date of Birth _____

PARENT/GUARDIAN INFORMATION

Mother _____ Father _____ Other _____
Name _____ HomePhone _____ WorkPhone _____
Address _____ Birth Date _____
Employer _____ Social Security # _____

COLLEGE STUDENT

Name of School _____ Address _____
Graduation Date _____ Part Time _____ Full Time _____

We make every effort to keep down the cost of your oral surgical care. Payment is expected upon completion of each visit. If you have an insurance that our office is not participating with, after payment in full for services, a coded statement will be given to you so you can bill your insurance directly for your reimbursement.

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. **General anesthesia is not always a covered benefit. It is your responsibility to pay any deductible, co-insurance, charges for non-covered procedures (in some instances general anesthesia) or any other balance not paid for by your insurance company. A fee will be charged to your account for any returned checks.**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment of insurance benefits to this treating doctor, that otherwise would have been payable to me.

Signature _____ Date _____