

# 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.

## PATIENT INFORMATION *Email (for appt. confirmations) \_\_\_\_\_*

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Social Security Number \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Phone: \_\_\_\_\_ Cell Phone \_\_\_\_\_ May we text appointment 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 than 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 \_\_\_\_\_