

Joseph J. Radakovich, D.M.D., P.C.

Oral and Maxillofacial Surgeon

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PATIENT INFORMATION / PLEASE USE BLACK INK:

Male Female

NAME _____
LAST FIRST MI
ADDRESS _____
CITY STATE ZIP
EMPLOYER _____ FULL TIME PART TIME

DATE _____
SS# _____
DRIVER'S LICENSE# _____
BIRTH DATE _____ AGE _____

SINGLE MARRIED DIVORCED DOMESTIC PARTNER
 WIDOWED STUDENT CHILD
SPOUSE'S NAME _____
SCHOOL ATTENDING FULL TIME PART TIME

PHONE: Home (____) _____
Work (____) _____
Cell (____) _____
Email _____

REFERRED BY: _____ DENTIST: _____

PERSON RESPONSIBLE FOR BILL:

NAME _____
LAST FIRST MI
ADDRESS _____
CITY STATE ZIP
EMPLOYER _____

SS# _____
DRIVER'S LICENSE# _____
BIRTH DATE _____ AGE _____
PHONE: Home (____) _____
Work (____) _____

DENTAL INSURANCE

#1
SUBSCRIBER NAME _____ DOB ____/____/____
RELATIONSHIP TO PATIENT Self Spouse Parent Other
SUBSCRIBER ID# _____
EMPLOYER _____ GROUP # _____
INSURANCE CO. _____
INSURANCE CO. ADDRESS _____
CITY STATE ZIP
INSURANCE PHONE (____) _____

#2
SUBSCRIBER NAME _____ DOB ____/____/____
RELATIONSHIP TO PATIENT Self Spouse Parent Other
SUBSCRIBER ID# _____
EMPLOYER _____ GROUP # _____
INSURANCE CO. _____
INSURANCE CO. ADDRESS _____
CITY STATE ZIP
INSURANCE PHONE (____) _____

MEDICAL INSURANCE

#1
SUBSCRIBER NAME _____ DOB ____/____/____
RELATIONSHIP TO PATIENT Self Spouse Parent Other
SUBSCRIBER ID# _____
EMPLOYER _____ GROUP # _____
INSURANCE CO. _____
INSURANCE CO. ADDRESS _____
CITY STATE ZIP
INSURANCE PHONE (____) _____

#2
SUBSCRIBER NAME _____ DOB ____/____/____
RELATIONSHIP TO PATIENT Self Spouse Parent Other
SUBSCRIBER ID# _____
EMPLOYER _____ GROUP # _____
INSURANCE CO. _____
INSURANCE CO. ADDRESS _____
CITY STATE ZIP
INSURANCE PHONE (____) _____

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be paid directly to Joseph J. Radakovich D.M.D., P.C. I am financially responsible for non-covered services. I also authorize Joseph J. Radakovich D.M.D., P.C. to release any information required, related to insurance claims.

SIGNATURE _____ DATE _____