ORAL & MAXILLOFACIAL ASSOCIATES
PATIENT INFORMATION

DATE:____________________

DOCTOR:_________________________

First Name: ______________________________Middle Initial: ______ Last Name: ______________________

Sex: ☐ Male ☐ Female Date of Birth:__________________Social Security #:_________________________

Street Address: ____

City, State, and Zip Code:____

Home Phone:_________________________________ Work/Mobile Phone:______________________________

School:__________________________________(if applicable) Student: ☐ Full-time ☐ Part-time

Employer: ____Phone:___________________________________

PATIENT IS PERSON RESPONSIBLE FOR PAYMENT: ☐
PERSON RESPONSIBLE FOR PAYMENT (if other than the patient)

First Name: ________________Middle Initial:_____Last Name: _____________Relationship to Patient:_____________

Sex: ☐ Male ☐ Female Date of Birth:_________________ Social Security #:_______________________

Street Address:____

City, State, and Zip Code: ____

Home Phone:__________________________________Work/Mobile Phone:______________________________

Employer:____Phone:_____________________________

REFERRING DOCTOR/DENTIST:________________________________City and State:____________________

EMERGENCY CONTACT:

Name:____Relationship to Patient:___________________________

Street Address:____

City, State and Zip Code:____

Home Phone:____________________Work Phone:__________________Mobile Phone:____________________

OVER

DENTAL INSURANCE (if more than one Insurance Co., ☐ Check here and fill out the information below)

Insurance Company Name:______________________________Group #__________________

Insurance Company Address:______________________________Phone #__________________

Primary Care Physician Name:______________________________Phone #__________________

Type of Insurance: POS_____DMO_____HMO_____EPO_____PPO_____

POLICY HOLDER INFORMATION: (relationship of policy holder to the patient)__________________

First Name:________________Middle Initial:______Last Name:______________________

Date of Birth:____________Social Security #____________Home/Mobile Phone #'s__________________

Address, City, State, & Zip Code:____

Employer:______________________________________Phone #________________

MEDICAL INSURANCE (if more than one Insurance Co., ☐ Check here and fill out the information above)

Insurance Company Name:______________________________Group #__________________

Insurance Company Address:______________________________Phone #__________________

Primary Care Physician Name:______________________________Phone #__________________

Type of Insurance: POS_____DMO_____HMO_____EPO_____PPO_____

POLICY HOLDER INFORMATION: (relationship of policy holder to the patient)__________________

First Name:____________________Middle Initial:__________Last Name:__________________

Date of Birth:____________Social Security #____________Home/Mobile Phone # __________________

Address, City, State, and Zip Code:____

Employer:______________________________________Phone #________________

FEES AND PAYMENTS: We make every effort to keep down the cost of your oral surgical care. You can help by paying upon completion of each visit. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and / or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information at the top of the form. 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. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance.

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment directly to the dentist named on the insurance benefits otherwise payable to me.

SIGNATURE:______________________________________Date:______________