SOUTHEAST ORAL and MAXILLOFACIAL SURGERY

DATE

HAVE WE TREATED ANY OF YOUR FAMILY OR FRIENDS?
Name:

REFERRING DOCTOR OR SPECIALIST

REFERRING DENTIST

PATIENT INFORMATION

PATIENT'S NAME (First, Middle Initial, Last)
SEX ☐ Male ☐ Female

PATIENT'S ADDRESS

CITY | STATE | ZIP

AREA CODE/TELEPHONE
MARITAL STATUS ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
DATE OF BIRTH ___/ ___/ ___

AGE | SOCIAL SECURITY NUMBER | DRIVER'S LICENSE NUMBER

EMPLOYER'S NAME | AREA CODE/TELEPHONE

EMPLOYER'S ADDRESS | CITY | STATE

EMPLOYEMENT STATUS
☐ - Full Time ☐ - Retired
☐ - Part Time ☐ - Not Employed

STUDENT STATUS: If 19 Years or Older:
☐ - Full Time ☐ - Part Time ☐ - Not a student

INSURANCE INFORMATION *(Please write information about the patient's insurance here.)*

DENTAL INSURANCE COMPANY

INSURANCE COMPANY'S ADDRESS

CITY | STATE | ZIP

GROUP PLAN NUMBER | POLICY OR SUBSCRIBER'S NUMBER

TELEPHONE (   )

MEDICAL INSURANCE COMPANY

INSURANCE COMPANY'S ADDRESS

CITY | STATE | ZIP

GROUP PLAN NUMBER | POLICY OR SUBSCRIBER'S NUMBER

TELEPHONE (   )

POLICYHOLDER INFORMATION *Complete the information below if the PATIENT is not the POLICYHOLDER*

DENTAL POLICY HOLDER'S NAME (First, Middle Initial, Last) | DATE OF BIRTH ___/ ___/ ___

PRIMARY POLICY HOLDER'S ADDRESS | AREA CODE/TELEPHONE

CITY | STATE | ZIP

EMPLOYER'S NAME | AREA CODE/TELEPHONE

EMPLOYER'S ADDRESS

CITY | STATE | ZIP

SOCIAL SECURITY NUMBER
RELATIONSHIP TO PATIENT ☐ SPOUSE ☐ DEPENDENT ______ OTHER

EMPLOYER PLAN COVERAGE ☐ YES ☐ NO
IF CHAMPUS: ☐ Active ☐ Retired ☐ Deceased
Branch of Service ____________

MEDICAL POLICY HOLDER'S NAME (First, Middle Initial, Last) | DATE OF BIRTH ___/ ___/ ___

PRIMARY POLICY HOLDER'S ADDRESS | AREA CODE/TELEPHONE

CITY | STATE | ZIP

EMPLOYER'S NAME | AREA CODE/TELEPHONE

EMPLOYER'S ADDRESS

CITY | STATE | ZIP

SOCIAL SECURITY NUMBER
RELATIONSHIP TO PATIENT ☐ SPOUSE ☐ DEPENDENT ______ OTHER

EMPLOYER PLAN COVERAGE ☐ YES ☐ NO
IF CHAMPUS: ☐ Active ☐ Retired ☐ Deceased
Branch of Service ____________

RESPONSIBLE PARTY INFORMATION *Responsible party is:* ☐ *Patient* ☐ *Dental Policyholder* ☐ *Medical Policyholder*

Please complete the information below if the person responsible for paying the bill is not the PATIENT or the POLICYHOLDER.

NAME (First, Middle Initial, Last)
SEX ☐ Male ☐ Female

RESPONSIBLE PARTY'S ADDRESS | STATE | ZIP

AREA CODE/TELEPHONE
RELATIONSHIP TO PATIENT ☐ SPOUSE ☐ DEPENDENT ______ OTHER

SOCIAL SECURITY NO. | DRIVER'S LICENSE NO. | LEGAL REPRESENTATIVE ☐ Yes ☐ No

EMPLOYER'S NAME | AREA CODE/TELEPHONE

EMPLOYER'S ADDRESS | STATE | ZIP

I AGREE TO BE RESPONSIBLE FOR ALL FEES WHETHER COVERED BY INSURANCE OR NOT
I authorize the release of information necessary in the course of my treatment

PATIENT ACCOUNT NUMBER

X ______________________________ Date ____________
SIGNED (Patient, or parent if under 18 years of age.)