WELCOME TO ORAL SURGERY CENTER

Please take a few minutes to answer the following questions so we can better assist you with your oral surgery need.

PATIENT INFORMATION

Date _____ Account No._____

☐ Mr. ☐ Mrs. ☐ Dr. First Name _____ Last Name _____ M.I. ____

Sex: ☐ Male ☐ Female Birth Date _____Age _____ Social Security. # _____-____-____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor Have you ever been a patient of our practice? ☐ Yes ☐ No

Street _____ City _____ Apt # _____ State _____ Zip _____
Home Tel. (_____) _____ Cell. (_____) _____ E-mail _____

Dentist Name _____ Medical Doctor _____ who should we thank for referring you? _____

Employer _____ Occupation _____Bus. Tel. (_____) _____ Ext. _____
In case of Emergency, who should we contact? _____Relationship _____ Phone (_____) _____

Method of Personal Payment: ☐ Cash ☐ Check ☐ Credit Card

PRIMARY INSURANCE

Person Responsible for Account _____Last Name _____
Relationship to Patient _____Date of Birth_____Soc. Sec. # _____
Address _____ Home Phone _____
City _____State_____Zip _____
Responsible Party Employed By _____Business Phone _____
Business Address _____Occupation _____

Insurance Company _____Address _____
Subscriber I.D. # _____Group # _____

ADDITIONAL INSURANCE

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Insured Name _____Last Name _____

Relationship to Patient _____Date of Birth_____Soc. Sec. # _____

Address _____Home Phone _____

City _____State _____Zip Code _____

Insured Employed By _____Business Phone _____

Insurance Company Address _____Address _____

Subscriber I.D. # _____Group # _____