# – Patient Information Sheet –

Name: _____ Date: _____
First Middle Last

Address: _____
Street City State Zip

Sex: Male Female Birthdate: _____ Age _____ Soc. Sec.# _____

Home Tel.: _____ Work Tel.: _____ Cell: _____

Physician: _____ Dentist: _____

If student, name of school/college: _____ Full Time/ Part Time
(Circle One)

Employer: _____ Whom may we thank for referring you? _____

In the event of an emergency, who should we contact?
Name: _____ Relationship: _____ Home Tel.: _____

## Responsible Party (If patient is a minor)

Name: _____ Relationship: _____

Address (if different than above): _____

Home Tel.: _____ Soc. Sec.#: _____ Birthdate: _____

Employer: _____ Work Tel.: _____

## Dental Insurance Information

Name of Insured: _____ Relationship: _____ Phone # _____

Birthdate: _____ Soc. Sec.# or ID# _____

Insurance Company: _____ Insured's Employer _____ Work # _____

Insurance Address: _____
Street City State Zip

Insurance Tel.: _____ Group #: _____

## Secondary Insurance Information

Name of Insured: _____ Relationship: _____ Phone # _____

Birthdate: _____ Soc. Sec.# or ID# _____

Insurance Company: _____ Insured's Employer _____ Work # _____

Insurance Address: _____
Street City State Zip

Insurance Tel.: _____ Group #: _____

**Fees and Payments**

We make every effort to keep down the cost of your oral surgery care. Payment in full is expected at each appointment. For your convenience, we offer the following methods of payment; Cash, Check, Visa, MasterCard and Discover.

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payors and/or health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist. 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 on behalf of my dependent.

_____ _____
Signature of Patient or Parent (if minor) Date