

**PLEASE COMPLETE  
BOTH SIDES IN INK!**

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Oral and Maxillofacial Surgery

**PATIENT INFORMATION SHEET**

**Section I. Please bring picture identification of the patient or parent (guardian).**

Patient's First Name	Middle Initial	Last Name	DOB	Age
Address		City	State	Zip

If the above patient is 17 years or younger, complete section II.

**Section II.**

Parent/Guardian First Name	Middle Initial	Last Name	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Legal Guardian
Address (If different than above)		City	State	Zip	

Are you a student?  Yes  No Where? \_\_\_\_\_  Full-time  Part-Time  
If full-time student, please include proof of student status (bring schedule).

**Section III.**

Please contact me via my: Home Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_  
Work Phone ( ) \_\_\_\_\_ E-mail \_\_\_\_\_

Do you have insurance? \_\_\_\_\_ Yes \_\_\_\_\_ No If you answered no, you are finished with the front of this form.

If you answered yes, please complete section IV with both your dental and medical insurance information.  
Bring your insurance card(s) with you to the appointment.

**Section IV.**

Name of Insurance	Is this Medical, Dental Insurance or Both	Name of Employer
_____/_____/_____	Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Step-Parent <input type="checkbox"/> Legal Guardian	
Name of Employee	Employee DOB	

Employee Social Security Number	Insurance Identification Number	Contract Number	Group Number
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If there is more than 1 insurance, please complete again:

Name of Insurance	Is this Medical, Dental Insurance or Both	Name of Employer
_____/_____/_____	Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Step-Parent <input type="checkbox"/> Legal Guardian	
Name of Employee	Employee DOB	

Employee Social Security Number	Insurance Identification Number	Contract Number	Group Number
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Name of Employee	Employee DOB	

Employee Social Security Number	Insurance Identification Number	Contract Number	Group Number
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**Please arrive 15 minutes prior to your scheduled appointment time to complete your registration.**