

# Oral and Maxillofacial Surgical Specialists

## Personal and Financial Data

DATE:
CHART #
DOCTOR:

<b>PATIENT NAME</b> (Please Print)	Age	Date of Birth
<small>First</small> _____ <small>MI</small> _____ <small>Last</small> _____		
Mailing Address	Home Phone	
City _____ State _____ Zip Code _____	Work Phone	
Sex: M F      Marital Status: M S W D	Cell Phone	
Employer	Social Security Number	

Who referred you to our office?	Did you bring x-rays with you?
Personal Dentist	Primary Care Physician

Why are you seeing the doctor today?

<b>Person Responsible for Account</b> (If child, list attending parent information)	Relationship to Patient
<small>First</small> _____ <small>MI</small> _____ <small>Last</small> _____	
Street Address	Home Phone
City _____ State _____ Zip Code _____	Work Phone
Employer	SS#

### DENTAL INSURANCE

Primary Dental Carrier _____	Group # _____
Insured's Name _____	
Insured's Date of Birth _____	SS # _____ Employer _____
Secondary Dental Carrier _____	Group # _____
Insured's Name _____	
Insured's Date of Birth _____	SS# _____ Employer _____

### MEDICAL INSURANCE

Primary Medical Carrier _____	Group # _____
Insured's Name _____	
Insured's Date of Birth _____	SS# _____ Employer _____
Secondary Medical Carrier _____	Group # _____
Insured's Name _____	
Employer _____	

Does your Insurance require a referral? Yes  No       It is the patient's responsibility to obtain a referral from their Primary Care Physician.

Managed Care Plan? Yes  No       Point of Service Plan? Yes  No

### FINANCIAL AGREEMENT

I authorize Oral & Maxillofacial Surgical Specialists to furnish information to my Insurance Carriers concerning my illness and treatment, and hereby assign all payments for services rendered to myself or my dependent. I understand that I am responsible for any amount not covered by my insurance.

Signature _____	Date _____	Witness _____
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