Oral and Maxillofacial Surgical Specialists, P.C.

DATE:

CHART #:

DOCTOR:

Personal and Financial Data

PATIENT NAME (Please Print)		Age	Date of Birth
Mailing Address		Home Phone	
City	State Zip Code	Work Phone	
Sex: M F	Marital Status: M S W D	Cell Phone	
Employer		Social Securtiy 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?			
Person Responsible for Account? (If child, list attending parent information.) First MI Last		Relationship to Patient	
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 _____

Insured's Date of Birth _____ SS # _____ Employer _____

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

Financial Agreement

I authorize Oral and 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 I am responsible for any amount not covered by my insurance.

Signature _____ Date _____ Witness _____

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