

WELCOME TO OUR PRACTICE

() Mr. () Mrs. () Ms. () Dr. Last Name _____ First _____ M.I. _____ Nickname _____
Birth Date _____ Soc. Sec. # _____ Age _____ Drivers Lic.# _____
Street: _____ Apt: _____ City _____ State _____ Zip _____
Home Tel () _____ Cell () _____ Best time & place to reach me _____
Referred by _____ Your Dentist _____ Phone _____
Have you been a previous patient Yes No Family members we have seen _____
Employed Full time Part time Retired Unemployed Do you belong to a Dental HMO or PPO Yes No
Occupation _____ Employer _____ Address _____
Bus. phone () _____ How long employed there _____
 Single Married Divorced Legally Separated Widowed
Nearest relative not living with you _____ Home Tel () _____ Bus. Tel () _____
Relative's Home Address: _____
Student: Full time Part Time Not Name of School _____ City _____
Who is the person responsible for your account? (If self, skip to next section) Self Spouse Mother Father Other
Home Tel: () - _____ Bus. # () - _____ Ext: _____ Cell () - _____
Soc. Sec. # _____ Date of Birth _____ Age _____ Drivers Lic. # _____

PRIMARY DENTAL INSURANCE

Insured's Name _____ Relation _____
Insured's Birth date _____ M F
Insured's S. S. # _____ I.D. # _____
Insured employed by _____
Business Address _____
Name of Insurance Co. _____
Address _____ State _____ Zip _____
Ins. Co. tel. #. () _____
Group Plan or Policy # _____

SECONDARY DENTAL INSURANCE

Insured's Name _____ Relation _____
Insured's Birth date _____ M F
Insured's S. S. # _____ I.D. # _____
Insured employed by _____
Business Address _____
Name of Insurance Co. _____
Address _____ State _____ Zip _____
Ins. Co. tel. #. () _____
Group Plan or Policy # _____

PRIMARY MEDICAL INSURANCE

Insured's Name _____ Relation _____
Insured's Birth date _____ M F
Insured's S. S. # _____ I.D. # _____
Insured employed by _____
Business Address _____
Name of Insurance Co. _____
Address: City _____ State _____ Zip _____
Ins. Co. tel. #. () _____
Group Plan or Policy # _____

SECONDARY MEDICAL INSURANCE

Insured's Name _____ Relation _____
Insured's Birth date _____ M F
Insured's S. S. # _____ I.D. # _____
Insured employed by _____
Business Address _____
Name of Insurance Co. _____
Address: City _____ State _____ Zip _____
Ins. Co. tel. #. () _____
Group Plan or Policy # _____

Reason for today's office visit: _____

TO OUR PATIENTS:

While the financial and business aspects of an Oral & Maxillofacial Surgery practice are necessary to provide you with the care you deserve and expect, we want you to know that your health and well being come first, and are our primary concern.

Although we as Oral & Maxillofacial Surgeons treat the areas of the mouth, face, and jaws, health problems that you may have or medications that you may be taking could have an important relationship with the care you will be receiving.

Your answers to the health questions on the other side of this page are strictly confidential, and are for our records only.