Implants & Orofacial Surgery Specialists

PATIENT INFORMATION

First Name________________ Last Name________________ E-mail__________________
Phone (______)_______-_______ Alternate Phone (______)_______-________
Address____ Unit #______
City______________________ State_______________ Zip Code________________
SS#_____-____-______ Date of Birth___/___/______ Sex ___Male ___Female
Emergency Contact ______________________________ Phone (____)____-______

PARTY FINANCIALLY RESPONSIBLE
___*Self (same information as above)* ___*Parent/Guardian*

Full Name________________________________Relationship to patient________________
Address____ Unite #______
City______________________ State________________ Zip Code_________________
Phone (______)_______-________ Alternate Phone (______)_______-_________
SS#____-____-______ Date of Birth ___/____/______

INSURANCE INFORMATION
___ *Dental card was scanned in*

- Primary Dental Insurance_______________________________

ID#____________________________ Group #____________
Subscriber Name___________________________ Date of Birth ___/____/_____
Relationship to patient_____________________ Phone (_____)______-_________

- Secondary Dental Insurance_____________________________

ID#____________________________ Group #____________
Subscriber Name___________________________ Date of Birth ___/____/_____
Relationship to patient_____________________ Phone (_____)______-_________

PHARMACY INFORMATION
Pharmacy Name ______________________________
Pharmacy Phone (______)_______-_______
Address____ Unit #______
City______________________ State_______________ Zip Code________________

I confirm that the information I have provided is accurate to the best of my knowledge. Any falsification of information may lead to an unpredictable outcome. I have been made aware of the ***Notice of Privacy Practices* and ***Office Policies***, including office fees.**

Signature ____ Date___/___/_____