Oral & Facial Surgery

Patient Information

The following information is needed for our records.
Please print answers to all questions on this sheet.

Today's Date: _____ Your Age: _____

Who referred you to this office? _____ Dentist Name: _____ / Phone # _____

_____ _____ _____ _____
First Name MI Last Name Nickname

Street _____ City _____ State _____ Zip Code _____

Home Phone: _____ Work Phone: _____ Male ☐ Female ☐

Date of Birth: _____ Patient Social Security # _____ Occupation: _____

Employed by: _____ Address: _____

Marital Status: S M D W Name of Spouse: _____

Name of Relative/Friend: _____ Address: _____
(Not living with you.)

Phone: _____ Relationship to Patient: _____

Insurance Information

Primary Dental: _____
Claim / Benefits Phone #: _____
Claim Address: _____

Name of Insured: _____
Address: _____
ID# _____ Group # _____
SS# _____ D O B _____
Employer: _____
Marital Status: S M D W Male ☐ Female ☐
Relationship to Patient: _____

Second Dental Ins: _____
Claim / Benefits Phone #: _____
Claim Address: _____

Name of Insured: _____
Address: _____
ID# _____ Group # _____
SS# _____ D O B _____
Employer: _____
Marital Status: S M D W Male ☐ Female ☐
Relationship to Patient: _____

Primary Medical: _____
Claim / Benefits Phone #: _____
Claim Address: _____

Name of Insured: _____
Address: _____
ID# _____ Group # _____
SS# _____ D O B _____
Employer: _____
Marital Status: S M D W Male ☐ Female ☐
Relationship to Patient: _____

Secondary Medical: _____
Claim / Benefits Phone #: _____
Claim Address: _____

Name of Insured: _____
Address: _____
ID# _____ Group # _____
SS# _____ D O B _____
Employer: _____
Marital Status: S M D W Male ☐ Female ☐
Relationship to Patient: _____

Guarantor's name if other than patient or insured: _____

Guarantor's Home Phone: Work Phone: _____

Guarantor's Address: _____

Guarantor's Social Security #: _____ Date of Birth: _____

(Guarantor) is the person responsible for bill. (Insured) is the person who carries the insurance.