PATIENT INFORMATION (Please Print)

Title: _____ **First Name:** _____ **MI:** ____ **Last Name:** _____

Birthdate: _____ **Soc. Sec.:** _____ **Gender:** ◯ Male ◯ Female

Address: _____ **Apt./Suite:** _____

City: _____ **State:** _____ **Zip Code:** - _____

Phones: **Home:** ( ) - _____ **Work:** ( ) - _____ **Ext:** _____

Mobile: ( ) - _____ **Fax:** _____ **Email:** _____

Employer: _____ **Phone:** ( ) - _____ **Occupation:** _____

Referred By: Dr. _____ _____ **General Dentist:** _____ _____

Have you been seen in this practice before today? ◯ Yes ◯ No

PERSON RESPONSIBLE FOR ACCOUNT (if other than patient)

Title: _____ **First Name:** _____ **MI:** ____ **Last Name:** _____

Relationship to Patient: ☐ patient ☐ spouse ☐ child ☐ other - please specify _____ **Soc. Sec.:** _____

Address: _____ **Apt./Suite:** _____

City: _____ **State:** _____ **Zip Code:** _____

Phones: **Home:** ( ) - _____ **Work:** ( ) - _____ **Ext:** _____

Mobile: ( ) - _____ **Fax:** ( ) - _____ **Email:** _____

Employer: _____ **Phone:** _____ **Occupation:** _____

DENTAL INSURANCE INFORMATION

Primary Insurance

Ins. Co. _____

Group #: _____ **Phone:** _____

Employer: _____

Employee (if other than patient)

Name: _____ _____

Birthdate: _____ **Soc. Sec.:** - -

Subscriber #: _____ **Sex:** ◯ Male ◯ Female

Secondary Insurance

Ins. Co. _____

Group #: _____ **Phone:** _____

Employer: _____

Employee (if other than patient)

Name: _____ _____

Birthdate: _____ **Soc. Sec.:** - -

Subscriber #: _____ **Sex:** ◯ Male ◯ Female

I understand that I am financially responsible and agree to pay for all charges arising from my care. My fees will be based on my insurance contract, if one applies at the time of my care, and the care provided.My insurance may apply an alternate benefit for services rendered in my care. Assignment of an alternatebenefit is not intended to dictate my treatment but to establish benefits payable based on my insurances company's interpretation of my contract at the time of services. Charges are based on benefits billed by Center for Oral Surgery and Dental Implants who will not be responsible for changes to charges billed arising from assignment of alternate benefits. All payments are due on the day of services unless previously arranged. All surgical appointments require a deposit. To assure optimal use of Doctor's schedule we require a two business day prior notice for rescheduling/cancelling your appointment. Otherwise, deposit is non refundable.

_____ _____ _____ _____

Signature (parent or guardian if patient is a minor) Date Signature of authorized representative of Center For Oral Surgery And Dental Implants Date