

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	Secondary Insurance
Ins. Co. _____	Ins. Co. _____
Group #: _____ Phone: _____	Group #: _____ Phone: _____
Employer: _____	Employer: _____
Employee (if other than patient)	Employee (if other than patient)
Name: _____	Name: _____
Birthdate: _____ Soc. Sec.: - -	Birthdate: _____ Soc. Sec.: - -
Subscriber #: _____ Sex: <input type="radio"/> Male <input type="radio"/> Female	Subscriber #: _____ Sex: <input type="radio"/> Male <input type="radio"/> 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 alternate benefit is not intended to dictate my treatment but to establish benefits payable based on my insurance 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