

Patient Information

Mr. Mrs. Ms. Minor

First Name Last Name

Address City State Postal Code

Home Phone Cell Phone Work Phone

Date of Birth Age Social Security #

Employer Address Your Occupation

Referring Dentist or Physician Family Physician

Are you registering for a consult visit? Yes ___ No ___
Are you registering for same day surgery? Yes ___ No ___
Have you been a patient here prior to today? Yes ___ No ___

PARENT/ GUARDIAN / SPOUSE INFORMATION (if applicable)

First Name	Last Name	Relationship to patient
_____	_____	_____

Address	City	State	Postal Code
_____	_____	_____	_____

Home Phone	Cell Phone	Work Phone
_____	_____	_____

Person to contact in event of emergency

First Name	Last Name	Relationship to patient
_____	_____	_____

Home Phone	Cell Phone	Work Phone
_____	_____	_____

PRIMARY DENTAL INSURANCE

Insurance Company

Phone #

Name of Employer

Group ID

Name of Primary Insured

Social Security #

Insured Date of Birth

Relationship to Patient

SECONDARY DENTAL INSURANCE

Insurance Company

Phone #

Name of Employer

Group ID

Name of Primary Insured

Social Security #

Insured Date of Birth

Relationship to Patient

PRIMARY MEDICAL INSURANCE

Insurance Company

Phone #

Name of Employer

Group ID

Name of Primary Insured

Social Security #

Insured Date of Birth

Relationship to Patient

SECONDARY MEDICAL INSURANCE

Insurance Company

Phone #

Name of Employer

Group ID

Name of Primary Insured

Social Security #

Insured Date of Birth

Relationship to Patient

For children under 18 years of age, the parent accompanying the child to this appointment is deemed the responsible party for payment of this account.

INITIAL

ASSIGNMENT AND RELEASE: I hereby assign my insurance benefits to be paid directly to **Palm Valley Oral & Maxillofacial Surgery** and authorize the release of any information required to process my claims. I understand that regardless if I have insurance or not, that I am financially responsible for all services rendered. I authorize the use of this signature on all insurance submissions.

Signature of Patient/Responsible Party (if minor)

Date