ASSOCIATED ORAL & MAXILLOFACIAL SURGEONS

Patient Information (Confidential)

A B C

Name ______________________________ ❒ Male ❒ Female
Last First Middle Nickname

❒ Single ❒ Married ❒ Child ❒ Other Birthdate: _____ / _____ / _____ Age: ______ S.S.#: ____________

Address: ______________________________
Street City State Zip

How long at this address?: ____________ E-mail Address: ____________

Home Phone: (_____) ____________ Cell Phone: (_____) ____________ Work Phone: (_____) ____________

Employer: ____________ Occupation: ____________ No. Years Employed: ____________

Your General Dentist: ____________ Full-time student? ❒ Yes ❒ No

How did you hear about our office? Please check all that apply. ☐ Specialists/MD ____________

☐ Dentist ☐ Billboard ☐ Radio ☐ Yelp ☐ Google ☐ Facebook ☐ Friend ☐ Other ____________

Financial Party Information (Confidential)

❒ Same as above

Name ______________________________ ❒ Single ❒ Married ❒ Other
Last First Middle

Birthdate: _____ / _____ / _____ Age: ______ S.S.#: ____________ Relationship to Patient ____________

Billing Address: ______________________________
Street City State Zip

How long at this address?: ____________ E-mail Address: ____________

Home Phone: (_____) ____________ Cell Phone: (_____) ____________ Work Phone: (_____) ____________

Employer: ____________ Occupation: ____________ No. Years Employed: ____________

Spouse Information (Confidential)

Name ______________________________ Birthdate: _____ / _____ / _____
Last First Middle

Home Phone: (_____) ____________ Cell Phone: (_____) ____________ S.S. #: ____________

Employer: ____________ Occupation: ____________ No. Years Employed: ____________

Dental/Medical Insurance Information

We will need copies of all your insurance cards. Thank You!

Policy Holder's Name: ____________ Birthdate: _____ / _____ / _____ S.S.#: ____________

DENTAL Insurance Co.: ____________ ID#: ____________ Group No.: ____________

Insurance Co. Address: ____________ Insurance Co. Phone: ____________

MEDICAL Insurance Co.: ____________ ID#: ____________ Group No.: ____________

Insurance Co. Address: ____________ Insurance Co. Phone: ____________

Policy Holder's Employer: ____________ Relationship to Patient: ____________

Secondary Dental Insurance: ______________________________
Company Policy holder ID# Group#

Secondary Medical Insurance: ______________________________
Company Policy holder ID# Group#

Emergency Information

Name of nearest relative **not** living with you: ____________

Address: ____________

Phone: ____________ Relationship: ____________

I authorize my insurance benefits to be paid directly to Associated Oral & Maxillofacial Surgeons. I authorize Associated Oral Surgeons to release pertinent medical/dental information to my insurance company when requested, or to facilitate payment of a claim. I understand a credit bureau report may be obtained.

Signature of Patient (If under 18, signature of legal guardian): ____________ **Date:** ____________

Updates (date & initial) ____________

TURN FORM OVER AND COMPLETE OTHER SIDE →