South Suburban Oral & Maxillofacial Surgeons, LTD

Patient Information

First Name **Middle Initial** **Last Name** **Date of Birth** **Age**

Marital Status
□ Single □ Married □ Life Partner □ Divorced □ Separated □ Widowed □ Other

Gender
□ Male □ Female

Home phone **Cell Phone** **Work phone**

Home address **PO Box #** **Apt #**

City **State** **Zip**

Employment status
□ Full time □ Part time □ Self-employed □ Retired □ Unemployed □ Active Military □ Full-time Student □ Part-time Student

Employer **Employer phone**

Person Responsible for this Account

Relationship to Patient
□ Self (if same as patient "X" box and skip this section) □ Spouse □ Parent □ Guardian □ Other

First Name **Middle Initial** **Last name** **Date of Birth**

Home phone **Cell Phone** **Work phone**

Home address **PO Box #** **Apt #**

City **State** **Zip**

Employment status
□ Full time □ Part time □ Self-employed □ Retired □ Unemployed □ Active Military □ Full-time Student □ Part-time Student

Employer **Employer phone**

Insurance

Please give your insurance card(s) and picture ID to the receptionist

Dental Insurance **ID or SS#** **Group #**

Policy holder **Date of Birth** **Gender**
□ Male □ Female

Relationship to Patient
□ Self □ Spouse □ Parent □ Guardian □ Other

Employment status
□ Full time □ Part time □ Self-employed □ Retired □ Unemployed
□ Active Military □ Full-time Student □ Part-time Student

Address of insurance company **Phone number of insurance company**

Medical Insurance **ID or SS#** **Group #**

Policy holder **Date of Birth** **Gender**
□ Male □ Female

Relationship to Patient
□ Self □ Spouse □ Parent □ Guardian □ Other

Employment status
□ Full time □ Part time □ Self-employed □ Retired □ Unemployed
□ Active Military □ Full-time Student □ Part-time Student

Address of insurance company **Phone number of insurance company**

Please Sign Below

Assignment of Benefits: I authorize my insurance company to pay benefits directly to South Suburban Oral and Maxillofacial Surgeons for services rendered to myself or my dependents.

Date: _____ Signature: _____

Records Release: I authorize South Suburban Oral and Maxillofacial Surgeons to release any information, including billing and medical information to my referring doctor and insurance company.

Date: _____ Signature: _____