Stateline Oral & Maxillofacial Surgery, PC

PATIENT INFORMATION

Name____Birth Date ____/____/_____Age_______

Home Address____

City____________________________ State_____________________ Zip Code_____________

Home Phone______________________________Cell_______________________________________

Sex: ❐M ❐F Marital Status: ❐Single ❐Married ❐Divorced ❐Widow

Occupation ______________________________ Employer __________________________________

Emergency contact name_____________________________Phone Number______________________

Who is your Dentist?__________________________

DENTAL INSURANCE INFORMATION

Primary Insurance Company ____

Subscriber ID # ____

Do you have a Secondary Dental Insurance? O yes O no

For minors / patients with guardians

Who is legally responsible for this patient? __________________________________

Is this who is filling out this form? O yes O no

If not, who is filling out this form? ____

Relationship to patient: ____

I authorize payment of my dental/medical benefits directly to Stateline Oral & Maxillofacial Surgery, PC for all services, also the use of this signature on all insurance submissions. I authorize Stateline Oral & Maxillofacial Surgery, PC to release all information necessary to secure the payment of benefits.

Primary Dental Subscriber Signature:______________________________________Date:________________

Medical Subscriber Signature:____Date:________________