Stateline Oral & Maxillofacial Surgery, PC

PATIENT INFORMATION

Name_____Birth Date ____/____/____Age_____

Home Address_____

City_____ State_____ Zip Code_____

Home Phone_____ Cell phone _____

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

Social Security #_____-_____-_____

Occupation_____ Employer _____

Emergency contact name_____Phone Number_____

Who is your Dentist?_____ Orthodontist?_____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance Company _____Phone Number_____
Insurance Address_____
Primary Subscriber_____Birth Date_____/_____/_____
Subscriber ID # _____Policy Group # _____
Relationship to Patient_____Social Security #_____-_____-_____
Primary Subscriber Employer_____Business Phone_____

Secondary Dental Insurance Company _____Phone Number_____
Insurance Address_____
Secondary Subscriber_____Birth Date_____/_____/_____
Subscriber ID # _____Policy Group # _____
Relationship to Patient_____Social Security #_____-_____-_____
Secondary Subscriber Employer_____Business Phone_____

MEDICAL INSURANCE INFORMATION

Medical Insurance Company _____Phone Number_____
Insurance Address_____
Subscriber_____Birth Date_____/_____/_____
Subscriber ID # _____Policy Group # _____
Relationship to Patient_____Social Security #_____-_____-_____
Subscriber Employer_____Business Phone _____

I authorize payment of my dental/medical benefits directly to Stateline Oral & Maxillofacial Surgery, PC for all services and 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.

Patient or guardian Signature:_____Date:_____

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