Apex Oral Surgery

Today's Date_____

PATIENT INFORMATION:

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name_____ M.I._____ Last Name_____

Sex: ❑ Male ❑ Female Birth Date_____ Age_____ Soc. Sec. #_____ E-mail_____

Street_____ Apt._____ City_____ State_____ Zip_____

Home Tel.(_____)_____ Cell.(_____)_____ Have you ever been a patient of our practice? ❑ Yes ❑ No

Referred By_____ (FIRST NAME) _____ (LAST NAME) Has a family member ever been a patient of our practice? ❑ Yes ❑ No

Dentist_____ (FIRST NAME) _____ (LAST NAME) Orthodontist_____ (FIRST NAME) _____ (LAST NAME) Medical Dr._____ (FIRST NAME) _____ (LAST NAME)

Driver's Lic.# _____ Nearest relative not living with you_____ (FIRST NAME) _____ (LAST NAME) Tel.(_____)_____

Employer _____ Bus. Tel.(_____)_____ Personal Payment Type: ❑ Cash ❑ Check ❑ Credit Card

In case of emergency, please contact _____ Tel. (_____)_____ Relation_____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

❑ Self (If self, skip this section) ❑ Spouse ❑ Father ❑ Mother ❑ Other_____

Name_____ (FIRST NAME) _____ (LAST NAME) S.S.#_____ Birth Date_____ Age_____

Tel.(_____)_____ Cell. (_____)_____ E-mail_____

Street _____ Apt._____ City_____ State_____ Zip_____

Driver's Lic.#_____ Employer_____ Bus. Tel.(_____) _____

SPOUSE OR OTHER GUARANTOR INFORMATION: *(IF DIFFERENT FROM ABOVE)*

Name_____ (FIRST NAME) _____ (LAST NAME) Relation_____ S.S.#_____ Birth Date_____

Street _____ Apt._____ City_____ State_____ Zip_____

Tel. (_____) _____ Employer_____ Bus. Tel.(_____)_____

INSURANCE INFORMATION:

Student: . . . . . ❑ Full Time ❑ Part Time ❑ Not . . . . . School Name and Address_____ (SCHOOL NAME) _____ (ADDRESS)

Marital Status: . ❑ Married ❑ Divorced ❑ Widow ❑ Single ❑ Legally Separated _____ (CITY) _____ (STATE) _____ (ZIP)

Employed: . . . . ❑ Full Time ❑ Part Time ❑ Retired ❑ Not . . . . . Do you belong to a PPO or HMO? ❑ Yes ❑ No

PRIMARY DENTAL INSURANCE COMPANY:

Employer_____

Bus. Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____)_____ Plan_____

Ins. Co. Name_____ I.D. # _____

Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____)_____ Group Name_____

Group # _____ Insured Party_____ (FIRST NAME) _____ (LAST NAME)

Relation_____ Birth Date_____ Sex: ❑ M ❑ F

S.S. #_____ Tel.(_____)_____

Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

PRIMARY MEDICAL INSURANCE COMPANY:

Employer_____

Bus. Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____)_____ Plan_____

Ins. Co. Name_____ I.D. # _____

Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____)_____ Group Name_____

Group # _____ Insured Party_____ (FIRST NAME) _____ (LAST NAME)

Relation_____ Birth Date_____ Sex: ❑ M ❑ F

S.S. #_____ Tel.(_____)_____

Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

SECONDARY DENTAL INSURANCE COMPANY:

Employer_____

Bus. Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____)_____ Plan_____

Ins. Co. Name_____ I.D. # _____

Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____)_____ Group Name_____

Group # _____ Insured Party_____ (FIRST NAME) _____ (LAST NAME)

Relation_____ Birth Date_____ Sex: ❑ M ❑ F

S.S. #_____ Tel.(_____)_____

Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

SECONDARY MEDICAL INSURANCE COMPANY:

Employer_____

Bus. Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____)_____ Plan_____

Ins. Co. Name_____ I.D. # _____

Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____)_____ Group Name_____

Group # _____ Insured Party_____ (FIRST NAME) _____ (LAST NAME)

Relation_____ Birth Date_____ Sex: ❑ M ❑ F

S.S. #_____ Tel.(_____)_____

Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)