PALMETTO ORAL AND MAXILLOFACIAL SURGERY

PATIENT INFORMATION **Date**___________________

Name____________________________________Email________________SS#_____________

Single___Married___ Male___Female___DOB_____________________Age____________

DL#_______________Phone(H)____________(W)______________©_________________

Address________________________City_____________State_____Zip_______________

Employer____

General Dentist____________________Secondary Dental Specialist___________________

Student Information FT____PT____ School______________________________________

How did you find out about Palmetto Oral & Maxillofacial Surgery? (check all that apply)

Dentist Specialist Website TV Newspaper/Magazine

Friend____________________ Other_____________________

If the above person is not responsible for this account, please fill out the information below:

RESPONSIBLE PERSON

Name____________________________________ SS# __________________________

Address______________________ City_______________ State________ Zip________

DL#____________________ Phone(H)____________(W)___________©____________

INSURANCE SUBSCRIBER INFORMATION

Name________________________________SS#_______________________________

Relationship to patient_______________________________DOB__________________

Telephone(H)___________________(W)__________________©__________________

Address_____________________________City_____________State____Zip________

Employer____

DENTAL INSURANCE COMPANY____________________ID#_________________
MEDICAL INSURANCE COMPANY___________________ID#_________________

*IN ORDER TO FILE INSURANCE ON YOUR BEHALF WE MUST HAVE A COPY OF YOUR **MEDICAL & DENTAL** INSURANCE CARDS. THANK YOU.

How will you be paying for your visit today? Credit Card___Cash___Check___