LITTLE NECK BAY ORAL AND MAXILLOFACIAL SURGERY

WELCOME TO OUR OFFICE

(Please Print)

Today's Date:	Email:

PATIENT INFORMATION

Patient's Last Name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Dentist Name:	Medical Doctor:	Height: Weight:	Birth Date: / /	Age:	Sex: ❑ M ❑ F

Patient's Street address:	Social Security no.:	Primary phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Referred to office by (please check one box): ❑ Dr. ________ ❑ Insurance Plan ❑ Google

❑Family ❑ Friend ❑ Close to home/work ❑ Yelp! ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No Please indicate **primary dental insurance**:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Little Neck Bay Oral and Maxillofacial Surgery or insurance company to release any information required to process my claims.

Patient/Guardian signature: ________________________________ **Date:** ______________________