Huntsville Oral and Maxillofacial Surgery Associates, P.C.
2314 Pansy Street
Huntsville, Alabama 35801
Telephone 256-534-5028

PATIENT INFORMATION

CELL PAGER # ________________

NAME ________________________________ HOME PHONE # ________________

DATE OF BIRTH ____________ GENDER M / F (CIRCLE ONE) SOCIAL SECURITY # ________________

HOME ADDRESS ________________ CITY ________________ STATE ______ ZIP ________

PATIENT'S OR PARENT'S EMPLOYER ________________________ WORK # ________________

EMPLOYER ADDRESS ________________ CITY ________________ STATE ______ ZIP ________

SPOUSE OR PARENT'S NAME ________________________ WORK # ________________

IF PATIENT IS A STUDENT, NAME OF SCHOOL/COLLEGE ________________________

PHYSICIAN ________________________________ PHONE # ________________

DENTIST ________________________________ PHONE # ________________

WHOM MAY WE CONTACT IN CASE OF EMERGENCY? ________________ PHONE # ____________

REFERRED BY: DENTIST ________ YELLOW PAGES ________ INTERNET ________ FRIEND ________

INSURANCE CO. ________________

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT ________________________

HOME PHONE # ________________ EMPLOYER ________________ WORK PHONE # ____________

HOME ADDRESS ________________ CITY ____________ STATE ______ ZIP ____________

DATE OF BIRTH ________________ SS# ________________ RELATION TO PATIENT ____________

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

INSURED NAME ________________________ RELATION TO PATIENT ________________

SS# ________________ DATE OF BIRTH ____________ EMPLOYER NAME ________________

INSURANCE COMPANY ________________ ID# ________________ GR# ________________

PRIMARY MEDICAL INSURANCE

INSURED NAME ________________________ RELATION TO PATIENT ________________

SS# ________________ DATE OF BIRTH ____________ EMPLOYER NAME ________________

INSURANCE COMPANY ________________ ID# ________________ GR# ________________

SECONDARY DENTAL INSURANCE

INSURED NAME ________________________ RELATION TO PATIENT ________________

SS# ________________ DATE OF BIRTH ____________ EMPLOYER NAME ________________

INSURANCE COMPANY ________________ ID# ________________ GR# ________________

SECONDARY MEDICAL INSURANCE

INSURED NAME ________________________ RELATION TO PATIENT ________________

SS# ________________ DATE OF BIRTH ____________ EMPLOYER NAME ________________

INSURANCE COMPANY ________________ ID# ________________ GR# ________________

THE UNDERSIGNED HEREBY AUTHORIZES THE DOCTOR TO TAKE RADIOGRAPHS, MODELS, PHOTOGRAPHS, OR ANY OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE TO MAKE A THOROUGH DIAGNOSIS. I UNDERSTAND THAT THE RESPONSIBILITY FOR PAYMENT FOR SERVICES PROVIDED FOR MYSELF OR DEPENDENTS IS MINE, DUE AND PAYABLE AT THE TIME SERVICES ARE RENDERED, UNLESS FINANCIAL ARRANGEMENTS HAVE BEEN MADE. I FURTHER UNDERSTAND THAT A FINANCIAL CHARGE WILL BE ADDED TO ANY OVERDUE BALANCE. I UNDERSTAND THAT IF THIS ACCOUNT HAS TO BE SENT OUT FOR COLLECTION, I WILL BE RESPONSIBLE FOR ALL COLLECTION FEES, INCLUDING ATTORNEY FEES AND COURT COSTS. I CERTIFY THAT THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES TO THE ABOVE INFORMATION.

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SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE