WELCOME

Oral & Facial Surgery
for Adults & Children

(Mr., Mrs., Ms., Dr.) First _____ MI ___ Last _____ Nickname _____
Address _____
City _____ State _____ Zip _____
Phone Hm# (___)_____ Wk# (___) _____ Cell# (___) _____
Sex: M___ F___ Date of Birth _____ SS# _____
Employer/School _____ Single___ Married___ Widowed ____
Referred By _____
Dentist _____ Dental Specialist _____ Orthodontist _____
Have you or a family member ever been a patient of our practice: Yes ___ No ___ Name _____

Emergency Contact _____ Relationship_____ Phone# (___)_____

Responsible Party Name (**If patient is a minor, person completing paperwork**) _____
Date of Birth _____ SS# _____ Home # (___)_____
Street_____ City _____ State _____ Zip_____
Employer_____ Phone # (___) _____

PRIMARY DENTAL INSURANCE

Ins. Co. Name_____
ID #_____ Group #_____
Insured Party _____
Sex: M___ F___ DOB_____ Relation _____
Street _____
City_____ State___ Zip_____
Phone # (___) _____ SS# _____
Employer _____

PRIMARY MEDICAL INSURANCE

Ins. Co. Name_____
ID #_____ Group #_____
Insured Party _____
Sex: M___ F___ DOB_____ Relation _____
Street _____
City_____ State___ Zip_____
Phone # (___) _____ SS# _____
Employer _____

SECONDARY DENTAL INSURANCE

Ins. Co. Name_____
ID #_____ Group #_____
Insured Party _____
Sex: M___ F___ DOB_____ Relation _____
Street _____
City_____ State___ Zip_____
Phone # (___) _____ SS# _____
Employer _____

SECONDARY MEDICAL INSURANCE

Ins. Co. Name_____
ID #_____ Group #_____
Insured Party _____
Sex: M___ F___ DOB_____ Relation _____
Street _____
City_____ State___ Zip_____
Phone # (___) _____ SS# _____
Employer _____

This signature verifies that the above information is accurate and complete to the best of my knowledge. If applicable, I authorize my insurance company to pay Dr. Smeltzer, Dr. Masonbrink or Dr. Frey all insurance benefits otherwise payable to me. I authorize the release of all information necessary to secure the payment of benefits.

How would you like your appointment comfirmed?
Email _____ Phone Call _____ Text Message _____

Signature (Patient or Guardian if Minor)_____ Date _____