

ALAMO MAXILLOFACIAL SURGICAL ASSOCIATES, PA

PATIENT INFORMATION:					
Prefix	First	Middle	Last	Suffix	Preferred Name/Nickname
					Male/Female <i>(please circle)</i>
Street/PO Box		City	State	Zip	
Home Telephone		Work Telephone		Mobile Telephone	Birthdate
				Single / Married / Divorced / Widowed	
Social Security Number		Driver's License Number (State)		Marital Status <i>(please circle)</i>	
Family Physician		General Dentist		Who Referred You To Our Practice?	
		Part Time/Full Time/Retired <i>(please circle)</i>		Part Time / Full Time <i>(please circle)</i>	
Employer		Name of School (if a student)			
Your Email Address (optional)		Emergency Contact		Relationship to Patient	Telephone

RESPONSIBLE BILLING PARTY (present with patient):					
Prefix	First	Middle	Last	Suffix	Preferred Name/Nickname
					Male/Female <i>(please circle)</i>
Street/PO Box		City	State	Zip	
Home Telephone		Work Telephone		Mobile Telephone	Birthdate
				Single / Married / Divorced / Widowed	
Social Security Number		Driver's License Number (State)		Marital Status <i>(please circle)</i>	

PRIMARY MEDICAL INSURANCE: Relationship to Patient <i>(please circle)</i> : Self / Spouse / Parent		SECONDARY MEDICAL INSURANCE: Relationship to Patient <i>(please circle)</i> : Self / Spouse / Parent	
Insurance Company	Name of Insured	Insurance Company	Name of Insured
Insured's ID Number	Insured's Date of Birth	Insured's ID Number	Insured's Date of Birth
Group Number	Name of Employer	Group Number	Name of Employer

PRIMARY DENTAL INSURANCE: Relationship to Patient <i>(please circle)</i> : Self / Spouse / Parent		SECONDARY DENTAL INSURANCE: Relationship to Patient <i>(please circle)</i> : Self / Spouse / Parent	
Insurance Company	Name of Insured	Insurance Company	Name of Insured
Insured's ID Number	Insured's Date of Birth	Insured's ID Number	Insured's Date of Birth
Group Number	Name of Employer	Group Number	Name of Employer

I authorize payment of insurance benefits to be issued directly to Alamo Maxillofacial Surgical Associates, PA for any services rendered to me. I further authorize Alamo Maxillofacial Surgical Associates to release to my insurance carrier listed above any information necessary to determine benefits payable for related services. I understand that I am responsible for payment of services not covered and/or denied by my insurance carrier and, in the event my insurance company fails to remit payment within 60 days from the date of service, I am responsible for the balance of my account. A service charge of 18% per annum may be applied.

Signature of Patient (or Guardian)

Date