WELCOME TO OUR PRACTICE

Name: ____ Referring Dentist_______________________

Address: ___________________________City:___________ State:____________ Zip:__________

Home Phone: ______________ Work Phone: _________________ Cell Phone:_________________

SS#: ____________________________Email Address: ___________________________________

Sex: Male/Female DOB: _________ Age: __________

Employer: __________________________________ Occupation:_____________________________

In case of an emergency, please notify? _____________________________Phone #: ______________

Pharmacy: ___________________________________ Phone Number:_________________________

Insurance Information: Please give insurance cards to the receptionist.

Dental Insurance Carrier: _______________________________ Phone #: __________________

Policy Holder's Name: ___________________________________ SS #/ID#:__________________

Employed By: ____ DOB:_____________________

What is the patient's relationship to insured member? Self - Spouse – Child - Other

Medical Insurance Carrier: ______________________________ Phone #:____________________

Policy Holder's Name: ___________________________________ SS#/ ID:____________________

Employed By: ____ DOB:___ __________________

What is the patient's relationship to insured member? Self – Spouse – Child - Other

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to GPC Oral & Facial Surgery Center otherwise payable to me. I authorize the provider/s to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance and that preauthorization of benefits does not guarantee payment. I authorize the use of this signature on all insurance submissions. I agree that I am responsible for all fees incurred, if my account is turned over to a third party collector.

Patient / Parent's Signature: ____ Date: _____________

(OVER)