

**NORTHWEST ORAL & FACIAL SURGERY
DRS. CARNES, MONTGOMERY, COOK & HENERY**

PATIENT INFORMATION SHEET

First Name _____ Middle Initial _____ Last Name _____

Date of Birth _____ Age _____ Social Security Number _____ Home Phone _____

Business Phone _____

Street Address _____

City _____ State _____ Zip Code _____ Physician _____

Dentist _____ Referred by _____

Student Status Full Time/Part Time/NA
(circle one)

Marital Status Married/Divorced/Single
(circle one)

Employed Full Time/Part Time/Retired/NA
(circle one)

INSURANCE COMPANY:

INSURED PARTY:

Name _____

Name _____

Address _____

Relation to Patient Self/Spouse/Child/Other Insured Date
(circle one) of Birth _____

Phone _____

Insured Address _____

Does your plan cover Dental/Medical/Both
(circle one)

Group No. _____ Employer Name _____ Employer Phone _____

Employer Address _____ Occupation _____

SECONDARY INSURANCE COMPANY:

SECONDARY INSURED PARTY:

Name _____

Name _____

Address _____

Relation to Patient Self/Spouse/Child/Other Insured Date
(circle one) of Birth _____

Phone _____

Insured Address _____

Does your plan cover Dental/Medical/Both
(circle one)

Group No. _____ Employer Name _____ Employer Phone _____

Employer Address _____ Occupation _____

We make every effort to keep down the cost of your oral surgical care. You can help by paying upon completion of each visit. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have dental and/or medical insurance, we will be glad to file your claims in accordance with the information that you have provided above. Your signature on this form indicates that the information that you have provided is correct, and that you are authorizing us to file a claim if you have insurance coverage. This signature further authorizes us to release any information necessary to process your claim and authorizes your insurance company to make payment directly to our office.

Patient/Responsible Party Signature _____

Date _____