PATIENT INFORMATION SHEET

THEOHARIDIS & MEIER
ORAL & MAXILLOFACIAL SURGERY
DENTAL IMPLANT CENTER

Today's Date: _____

Patient Name: _____ Sex: Male____ Female____

Date of Birth: _____ Age: _____ Social Security No.: _____

Address: _____ Apt. #:_____ Po Box: _____

City: _____ State: _____ Zip: _____

Home Telephone: (_____) _____ Cell phone: (_____) _____

Email: _____ Preferred Reminder Method: Text ☐ Call ☐ Email ☐

Dentist: _____ Physician: _____ Referred by: _____

Parent Name (if patient is minor or dependent): _____ Parent Phone #:_____

Marital Status: Single __ Married __ Divorced__ Widow__ Family Previously Treated:_____

Student: Yes____ No____ School Name: _____ Full time ____ Part time____

I have received a copy of the office HIPAA policy: _____

Person Financially Responsible: _____ Date of Birth: _____ Relationship: _____

Address (if different than patient): _____

Insurance

Medical Insurance Co. _____

Insurance Co. Address: _____ Phone No.: (_____)_____

Policy ID No.:_____ Group No.:_____

Subscriber Name: _____ Date of Birth:_____

Patient relationship to Subscriber: Self _____ Spouse _____ Child _____ Other _____

Dental Insurance Co. _____

Insurance Co. Address: _____ Phone No.: (_____)_____

Policy ID No.:_____ Group No.:_____

Subscriber Name: _____ Date of Birth:_____

Patient relationship to Subscriber: Self _____ Spouse _____ Child _____ Other _____

Fees and Payments:

Please remember that insurance is not a substitute for payment. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.

This signature on file is authorization for the release of information necessary to process my claim. I hereby authorize payment directly to the doctor named of the benefits otherwise payable to me.

Signature: _____ **Date**: _____