University Oral Surgery Center
Patient Information

Name:_____
First Middle Last
Age:_____ Date of Birth:_____Marital Status:_____Gender: __Male __Female __Non-binary
Social Security Number:_____Driver's License Number:_____State:_____
Home Address:_____(Suite or Apt#):_____
City:_____State:_____ Zip Code:_____
Cell Phone:_____Home Phone:_____e-mail:_____
Patient's Occupation:_____Employed by:_____
Employer's Address:_____Business Phone:_____
Spouse/Guardian's Name:_____Relationship:_____

Purpose of your visit:_____

How were you referred to our office? ___Dentist ____Friend/Family ___Insurance ____Internet ____Other
Referred By:_____Relationship:_____

Person Financially Responsible:_____Relationship:_____
Address:_____City:_____Zip Code:_____
Social Security Number:_____ Home Phone:_____Cell Phone:_____

Insurance Information

Primary Dental Insurance:_____
Address:_____Phone:_____
Name of Primary Insured:_____Date of Birth:_____Group/ID Number:_____
Secondary Dental Insurance :_____
Address:_____Phone:_____
Name of Primany Insured:_____Date of Birth:_____Group/ID Number:_____
Medical Insurance :_____
Address:_____Phone:_____
Name of Primary Insured:_____Date of Birth:_____Group/ID Number:_____

To avoid misunderstandings regarding insurance, we wish our patients to know that all professional services rendered are charged to the patient and that PATIENTS ARE PERSONALLY RESPONSIBLE FOR PAYMENT OF FEES. We will prepare the necessary forms or reports to help you obtain your benefits from insurance companies. We do not render our services on the presumption that insurance companies will pay our fees.

I authorize this office to obtain or release medical information pertinent to patient care and collection of fees.
I authorize and request my insurance company to pay, directly to the doctor, insurance benefits otherwise payable to me.
I understand that insurance forms will be submitted on my behalf when applicable. I also acknowledge that the ultimate settlement of my account is my responsibility and not that of the insurance company.
I have had an opportunity to review the Notice of Privacy Practices.

Signature of Patient/Legal Guardian:_____Date:_____