

# NORTHEAST ORAL & MAXILLOFACIAL SURGERY



## Patient Information

page 1

Mr. Mrs. Ms. Miss Dr. \_\_\_\_\_  
First MI Last Nickname

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Home \_\_\_\_\_  Work \_\_\_\_\_  Cell \_\_\_\_\_ (Check which phone number you would like us to use to contact you.)

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex: Male Female Age \_\_\_\_\_ Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Single Married Divorced

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Your Dentist \_\_\_\_\_ Physician \_\_\_\_\_ Orthodontist \_\_\_\_\_

Who referred you to our office? Dentist Physician Orthodontist Friend \_\_\_\_\_ Other

Have you or any family member ever been a patient of NEOMS?  no  yes If yes, what year? \_\_\_\_\_

Who \_\_\_\_\_ Relationship \_\_\_\_\_

Is patient a full-time student?  no  yes Name of School \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Is someone other than the patient responsible for this account?  no  yes If yes, please complete the following information:

Name \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SSN# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

## PRIMARY INSURANCE COVERAGE INFORMATION

### PRIMARY DENTAL INSURANCE

copy of card

Insurance Co. Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Name of Insured \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Insured Daytime Phone \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Insured SSN# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Plan ID (if other than SSN#) \_\_\_\_\_

Employer Name \_\_\_\_\_ Group # \_\_\_\_\_ (List secondary dental insurance on page 2.)

### PRIMARY MEDICAL INSURANCE

copy of card

Insurance Co. Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Name of Insured \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Insured Daytime Phone \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Insured SSN# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Plan ID (if other than SSN#) \_\_\_\_\_

Employer Name \_\_\_\_\_ Group # \_\_\_\_\_ (List secondary medical insurance on page 2.)

I understand in signing this statement that I am financially responsible to Northeast Oral & Maxillofacial Surgery (NEOMS) for all fees incurred and all costs of collection, including but not limited to service, collection, collection agency, and attorney charges, if necessary. I hereby authorize the insured's insurance company to pay directly to NEOMS any and all of the benefits otherwise payable to me. I further authorize the release of health care information for the purpose of evaluating and administering claims for benefits.

Patient Signature or Parent/Guardian if Patient is a Minor

Printed Name

Date

# NORTHEAST ORAL & MAXILLOFACIAL SURGERY



## Patient Information

page 2

First

MI

Last

Nickname

### SECONDARY INSURANCE COVERAGE INFORMATION

#### SECONDARY DENTAL INSURANCE

copy of card

Insurance Co. Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Name of Insured \_\_\_\_\_ DOB \_\_\_ / \_\_\_ / \_\_\_ Insured Daytime Phone \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Insured SSN# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Plan ID (if other than SSN#) \_\_\_\_\_

Employer Name \_\_\_\_\_ Group # \_\_\_\_\_

#### SECONDARY MEDICAL INSURANCE

copy of card

Insurance Co. Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Name of Insured \_\_\_\_\_ DOB \_\_\_ / \_\_\_ / \_\_\_ Insured Daytime Phone \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Insured SSN# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Plan ID (if other than SSN#) \_\_\_\_\_

Employer Name \_\_\_\_\_ Group # \_\_\_\_\_

#### AUTOMOBILE ACCIDENT

Insurance Co. Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Name of Insured \_\_\_\_\_ DOB \_\_\_ / \_\_\_ / \_\_\_ Insured Daytime Phone \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Insured SSN# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Plan ID (if other than SSN#) \_\_\_\_\_

Employer Name \_\_\_\_\_ Group # \_\_\_\_\_

#### WORKERS COMPENSATION

Insurance Co. Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Name of Insured \_\_\_\_\_ DOB \_\_\_ / \_\_\_ / \_\_\_ Insured Daytime Phone \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Insured SSN# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Plan ID (if other than SSN#) \_\_\_\_\_

Employer Name \_\_\_\_\_ Group # \_\_\_\_\_

**Accident/Workers Compensation Information** (Please describe how your accident occurred.) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_