

ORAL & FACIAL SURGERY

OF OKLAHOMA

REGISTRATION

Referred by: _____

Date: _____

PATIENT INFORMATION:

Last Name: _____ First Name: _____ Middle Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Home: _____ Phone Work: _____

SS#: _____ DL State & #: _____ Sex: _____ Date of Birth: _____

NAME OF RESPONSIBLE PARTY:

Last Name: _____ First Name: _____ Middle Name: _____

Relationship to Patient: _____ SS#: _____

Address if different from patient: _____

Phone Home: _____ Phone Work: _____

Employer: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

In case of emergency, contact: _____ Phone: _____

INSURANCE INFORMATION:

Please complete the information below and present insurance cards to the receptionist

DENTAL	MEDICAL
Name of Insured:	
Phone Work:	
Date of Birth:	
Relationship to Patient:	
SS#:	
Policy/Group #:	
Employer:	
Insurance Co Name:	
Insurance Co Phone #:	
Claims Address:	

INSURANCE AUTHORIZATION ASSIGNMENT

I hereby authorize all/any doctors associated with ORAL & FACIAL SURGERY OF OKLAHOMA to furnish information to insurance carriers concerning illness/accident or any treatments. I hereby assign to the physician(s) all payments for dental/medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

FINANCIAL RESPONSIBILITY AGREEMENT

It is the policy of this office to require full payment for your office exam and x-rays (if required) at the time of the exam. I understand that even though I may have some type of insurance coverage, I am fully responsible for payment of services rendered.

I HAVE READ THE PAYMENT OPTIONS ON THE LAST PAGE OF THESE FORMS AND FULLY UNDERSTAND THEM.

Date: _____ Signature of Responsible Party: _____