CONFIDENTIAL PATIENT INFORMATION

Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Previous Address (if less than 3 years) _____
_____
Sex _____ Age _____ Birth _____
Social Security Number _____
Marital Status _____
Spouse Name _____

Work Phone Number _____
Employer _____
Employer Address _____
City _____ State _____ Zip _____
How Long Employed _____
Drivers License No. _____
Referred By _____
General Dentist _____
Physician _____
Reason For Visit _____

Financial Responsible Party Information

Relationship To Patient _____
Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Previous Address _____
_____
Drivers License No. _____

Birthday _____
Social Security No. _____
Employer _____
Employer Address _____
City _____ State _____ Zip _____
Work Phone No. _____
How Long Employed _____

Insurance Information

Dental Insurance _____
Ins. Co. Address _____
City _____ State _____ Zip _____
Policy Holder _____
Ins. Co. Phone Number(_____) _____
Policy No./Group No. _____

Medical Insurance _____
Ins. Co. Address _____
City _____ State _____ Zip _____
Policy Holder _____
Ins. Co. Phone Number(_____) _____
Policy No./Group No. _____

Emergency Information

Name of the nearest relative NOT living with you _____ (Relationship) _____
Complete Address _____
Phone _____

Please Initial All Paragraphs And Sign At Bottom.

_____ I hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself or my dependents by **Gateway Oral and Maxillofacial Surgeons of St. Louis, P.C.** I further expressly agree and acknowledge that my signature on this document authorizes my doctor to submit claims for benefits, for services rendered, or for service to be rendered, without obtaining my signature on each and every claim to be submitted for myself or my dependents, and that I will be bound by this signature as though the undersigned has personally signed the particular claim.

_____ I understand that all insurance payments will be made directly to the doctor, unless otherwise specified by me.

_____ I acknowledge that I will be personally responsible for any and all charges not covered by my insurance.

_____ _____
Signature of Responsible Party Date