PATIENT INFORMATION ***West Coast Oral Surgery***

(Mr., Mrs., Ms., Dr.) **First Name:** _____ M.I._____ **Last Name:** _____

Age: _____ Date of Birth: _____ Sex: ( ) Male ( ) Female Social Security #: _____

Street: _____ Apt #_____ City: _____ State: _____ Zip: _____

Home Tel. ( ) _____ **Mobile**: ( ) _____ ***PLEASE NOTE ~ reminders will be***

E-MAIL Address_____ ***emailed and texted unless opted out***

Driver's License #: _____ Driver's License State: _____ Occupation: _____

Primary Dentist: _____ Referred By: _____ Primary Physician: _____

If someone else is responsible for your account *or making your appointments*, please complete:

Who will be responsible (guarantor) for your account? Relation: ( )Spouse ( )Mother ( )Father ( )Other _____

Name: _____ DOB: _____ Home Tel: ( )_____ **Mobile**: ( )_____

Street:_____ City:_____ State:_____ Zip:_____

E-MAIL:_____ _____ Social Sec.#_____

Driver's License #_____ Driver's License State: _____ Employer: _____

In case of EMERGENCY, contact: _____ Relationship to Patient: _____

Home Tel. ( ) _____ Work Tel. ( ) _____ Mobile Phone: ( ) _____

INSURANCE COMPANY INFORMATION (to assist in utilizing your insurance benefits, please be thorough as possible):

	The information below is required if you do not have your insurance card(s) with you.	**The information below is required if the primary subscriber is different than the guarantor above or if there is a secondary subscriber.**
Primary Dental Insurance	Ins. Co. Name:_____ Address:_____ City:_____ State:____ Zip:_____ Phone: ( ) _____ Group#_____ Employer Name:_____ START DATE OF PRIMARY INS.: _____	Primary Subscriber:_____ Relationship to Patient: ( )Spouse ( )Father ( ) Mother ( )Stepfather ( )Stepmother ( )Other _____ Date of Birth:_____ Phone: ( )_____ Social Security#_____ or Subscriber ID# _____
Secondary Dental Insurance	Ins. Co. Name:_____ Address:_____ City:_____ State:____ Zip:_____ Phone: ( ) _____ Group#_____ Employer Name:_____ START DATE OF SECONDARY INS.: _____	Secondary Subscriber:_____ Relationship to Patient: ( )Spouse ( )Father ( ) Mother ( )Stepfather ( )Stepmother ( )Other _____ Date of Birth:_____ Phone: ( )_____ Social Security#_____ or Subscriber ID# _____
Medical Insurance	Ins. Co. Name:_____ Address:_____ City:_____ State:____ Zip:_____ Phone: ( ) _____ Group#_____ Employer Name:_____	Primary Subscriber:_____ Relationship to Patient: ( )Spouse ( )Father ( ) Mother ( )Stepfather ( )Stepmother ( )Other _____ Date of Birth:_____ Phone: ( )_____ Social Security#_____ or Subscriber ID# _____

FEES AND PAYMENTS: We make every effort to help you manage the costs of your oral surgical care. You can assist by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. **An estimate of the charges** for any procedure or surgery you may require will be given to you. If you have any dental and/or medical insurance, we will be able to complete the proper insurance forms as a courtesy to you. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, coinsurance, co-pays, estimated patient portion, or any other balance not paid for by your insurance carrier upon delivery of service.**

This signature on file is my authorization for the release of any information necessary to process my claim. I hereby authorize payment directly to the doctor named on the insurance benefits otherwise payable to me. I agree to pay all reasonable costs and attorney's fees, if I do not pay any of the bills incurred.

Signature of Patient or Legal Guardian Representing Patient (Guarantor):_____ **Date:**_____