



Drs. Posek, Donlevy, and Ying

Oral and Maxillofacial Surgery • Dental Implants

New Patient Information

RB WC CC

ABOUT THE PATIENT

NAME: _____
Last First MI

Birth date ____/____/____ AGE ____ SS# ____ - ____ - ____

Home Address _____ Apt# _____

City _____ State _____ ZIP _____

Mailing Address if different: _____

Home Phone # _____ Cell Phone # _____

Employer: _____

Work Phone # _____

Spouse/Parent name _____

Emergency Contact _____

Emergency Contact Phone # _____

Referred to our office by _____

Current dentist _____

Date of Last Exam ____/____/____

Current orthodontist _____

Date of Last Exam ____/____/____

Medical physician's name _____

Phone number _____

Date of last exam ____/____/____

DENTAL INSURANCE

Primary Dental Insurance

Subscriber's Name _____

Subscriber's Employer _____

Subscriber's SS/ID# _____

Subscriber's Birth date ____/____/____

Relationship to Patient SELF SPOUSE PARENT

Insurance Company _____

Please provide copy of dental insurance card

Secondary Dental Insurance

Subscriber's Name _____

Subscriber's Employer _____

Subscriber's SS/ID# _____

Subscriber's Birth date ____/____/____

Relationship to Patient SELF SPOUSE PARENT

Insurance Company _____

Please provide copy of dental insurance card

MEDICAL INSURANCE

Subscriber's Name _____

Subscriber's Employer _____

Subscriber's SS/ID# _____

Subscriber's Birth date ____/____/____

Relationship to Patient SELF SPOUSE PARENT

Insurance Company _____

Please provide copy of medical insurance card

I understand that the information given here is, to the best of my knowledge, correct. I also understand this information will be held in STRICT CONFIDENCE. It is my responsibility to inform this office of any changes in my medical or financial status. WITH MY INFORMED CONSENT, I AUTHORIZE ANY NECESSARY SURGICAL SERVICE(S) INDICATED DURING DIAGNOSIS AND TREATMENT TO BE PERFORMED. If I have insurance, I hereby authorize my insurance benefits to be paid directly to the surgeon. I also authorize the surgeon and staff to release any information required for payment to be made. I understand that benefits differ with every insurance plan and I am ultimately responsible for determination of my own insurance benefits with my carrier. Depending on my insurance coverage, I may owe a balance after my insurance company has reimbursed the surgeon. I understand that I WILL BE financially responsible for any balance that is due.

Patient Signature (Parent or Guardian if Patient is a MINOR) _____ Date: _____

(REV 9/24//07)

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