Knoxville Oral & Maxillofacial Surgery, PC

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PERSONAL AND FINANCIAL DATA

PATIENT NAME (Please Print): First MI Last	Age	Date of Birth
Street Address	Home Phone	
City State Zip Code	Work Phone	
Sex: M F Marital Status: M S W D	SS#	Cell Phone
Are you a student? Yes ❑ No ❑ Full-Time ❑ Part-Time ❑	Name/Address of School Attending	
Employer Name, Address, Phone Number		
Who referred you to our office?	Did you bring x-rays with you?	
Personal Dentist	Primary Care Physician / Name & Telephone Number	
Why are you seeing the doctor today?		
Person Responsible for Account (if child, list attending parent information) First MI Last	Relationship to Patient	
Street Address	Home Phone	Cell Phone
City State Zip Code	Work Phone	
Employer	SS#	Birthdate

DENTAL INSURANCE

Primary Dental Carrier ____________ Group# ____________
Insured's Name ____________ ID# ____________
Insured's Date of Birth ____________ SS# ____________ Employer ____________
Secondary Dental Carrier ____________ Group# ____________
Insured's Name ____________ ID# ____________
Insured's Date of Birth ____________ SS# ____________ Employer ____________

MEDICAL INSURANCE

Primary Medical Carrier ____________ Group# ____________
Insured's Name ____________ ID# ____________
Insured's Date of Birth ____________ SS# ____________ Employer ____________
Secondary Medical Carrier ____________ Group# ____________
Insured's Name ____________ ID# ____________
Insured's Date of Birth ____________ SS# ____________ Employer ____________

Does your insurance require a referral? Yes ❑ No ❑ It is the patient's responsibility to obtain a referral from their Primary Care Physician.
Managed Care Plan? Yes ❑ No ❑ Point of Service Plan? Yes ❑ No ❑

FINANCIAL AGREEMENT

I authorize Knoxville Oral & Maxillofacial Surgery, PC, to furnish information to my Insurance Carriers concerning my illness and treatment, and hereby assign all payments for services rendered to myself or my dependent. I understand that I am responsible for any amount not covered by my insurance.

Signature ____________ Date ____________ Witness ____________