MINNESOTA ORAL AND MAXILLOFACIAL SURGERY, PA

PATIENT INFORMATION

(LAST NAME) (FIRST NAME) (MI)	BIRTHDATE	AGE	MALE ☐ FEMALE ☐
STREET ADDRESS	CITY / STATE	ZIP CODE	MARITAL STATUS:
HOME PHONE # / CELL PHONE # / WORK PHONE #	EMAIL ADDRESS:		

REFERRING DOCTOR

DENTIST: ORTHODONTIST: MD:

HAVE YOU OR A FAMILY MEMBER BEEN A PATIENT HERE BEFORE: ☐ YES ☐ NO IF YES, WHO:

EMPLOYMENT/SCHOOL INFORMATION

PATIENT'S EMPLOYER: JOB TITLE:

EMPLOYMENT OR STUDENT STATUS:
FULL TIME ☐ RETIRED ☐
PART TIME ☐ SELF EMPLOYED ☐
UNEMPLOYED ☐

PATIENT'S SCHOOL NAME IF STUDENT:

EMERGENCY CONTACT INFORMATION:

NAME: PHONE #: RELATIONSHIP:

IF MINOR, LIST BOTH PARENT'S FULL NAMES:

MOTHERS NAME:	FATHER'S NAME:
DOB:	DOB:
CONTACT PHONE #:	CONTACT PHONE #:

TO RESPECT YOUR PRIVACY, HOW CAN WE REACH YOU REGARDING YOUR HEALTH INFORMATION, LAB TEST RESULTS, MEDICATION AND BILLING?

CHOOSE ALL THAT APPLY:

☐ 1 LEAVE MESSAGE ON VOICE MAIL:
☐ HOME ☐ CELL PHONE ☐ WORK PHONE

☐ 2 DO NOT LEAVE MESSAGE ON VOICE MAIL

☐ 3 LEAVE MESSAGE WITH:_____
NAME RELATIONSHIP

RELEASE OF INFORMATION

Being of legal age, I authorize _____ to (parent/guardian) receive information regarding my account and medical records.

PLEASE INITIAL:

PATIENT:_____

PARENT/GUARDIAN:_____

INSURANCE INFORMATION

PRIMARY INSURANCE:	SECONDARY INSURANCE:
ID OR SS#:	ID OR SS#:
GROUP #:	GROUP #:
POLICYHOLDER: DOB:	POLICY HOLDER: DOB:
EMPLOYER:	EMPLOYER:
RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD	RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD

Clinic Credit Information: It is customary to pay for services the day they are rendered. We will file your claim with your insurance company for you. Estimated co-insurance , deductibles and non covered services are due on the date of service. As the responsible party of this account, I assume full responsibility for payment of dental/medical services, finance charges (1.5% per month), collection and attorney fees required in the collection of this account. There will be a $25 service charge applied to your account for any returned checks.

Assignment of Benefits: I hereby authorize and direct any insurance company to pay the proceeds of any benefits due me for services rendered by MINNESOTA ORAL SURGERY directly to the provider. A copy of this can be considered as an original for insurance purposes.

Notice of Privacy Practice Acknowledgement: I have reviewed the Notice of Privacy Practices

Release of Information: I authorize MINNESOTA ORAL SURGERY to release copies, or fax copies, inculding diagnosis and records of treatment concerning my medical records to insurance companies, physicians, dentists, hospitals or law officed for purposes of quality review.

X_____ **DATE:**_____

Patient signature (or signature of parent/guardian)