

# Stateline Oral & Maxillofacial Surgery, PC

## PATIENT INFORMATION

Name \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_  
Home Address \_\_\_\_\_ Apt. Number \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ Cell \_\_\_\_\_  
Sex: M F Marital Status: Single Married Divorced Widow Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Patient Employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_ Email \_\_\_\_\_

Emergency contact name \_\_\_\_\_ Phone Number \_\_\_\_\_

Whom may we thank for referring you here today? \_\_\_\_\_  
Who is your Dentist? \_\_\_\_\_ Orthodontist? \_\_\_\_\_

## DENTAL INSURANCE INFORMATION

Primary Dental Insurance Company \_\_\_\_\_ Phone Number \_\_\_\_\_  
Insurance Address \_\_\_\_\_  
Primary Subscriber \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Subscriber ID # \_\_\_\_\_ Policy Group # \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_ Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Primary Subscriber Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

Secondary Dental Insurance Company \_\_\_\_\_ Phone Number \_\_\_\_\_  
Insurance Address \_\_\_\_\_  
Secondary Subscriber \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Subscriber ID # \_\_\_\_\_ Policy Group # \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_ Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Secondary Subscriber Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

## MEDICAL INSURANCE INFORMATION

Medical Insurance Company \_\_\_\_\_ Phone Number \_\_\_\_\_  
Insurance Address \_\_\_\_\_  
Subscriber \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Subscriber ID # \_\_\_\_\_ Policy Group # \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_ Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Subscriber Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

I authorize payment of my dental/medical benefits directly to Stateline Oral & Maxillofacial Surgery, PC for all services, also the use of this signature on all insurance submissions. I authorize Stateline Oral & Maxillofacial Surgery, PC to release all information necessary to secure the payment of benefits.

Primary Dental Subscriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Secondary Dental Subscriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Medical Subscriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_