UPSTATE
Oral & Maxillofacial Surgery
& Dental Implant Center

PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. First Name _____ MI _____ Last Name _____

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

Address _____ Apt. _____ City _____ State _____ Zip _____

Home # (_____) _____ Cell (_____) _____ Email Address _____

Did you find our practice online? ☐ Yes ☐ No Referred by _____

Have you ever been a patient of our practice? ☐ Yes ☐ No Has a family member ever been a patient of our practice? ☐ Yes ☐ No

Dentist _____ Orthodontist _____ Medical Dr. _____

Driver's License # _____ Nearest relative not living with you (Name) _____ Tel. (_____) _____

Employer _____ Tel. (_____) _____ Personal Payment Type: ☐ Cash ☐ Check ☐ Card

Emergency Contact _____ Tel. (_____) _____ Relation _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT

☐ Self (If self, skip this section) ☐ Spouse ☐ Father ☐ Mother ☐ Other _____

Name _____ S.S.# _____ DOB _____ Age _____

Home # (_____) _____ Cell (_____) _____ Email Address _____

Address _____ Apt. _____ City _____ State _____ Zip _____

Driver's License # _____ Employer _____ Tel. (_____) _____

SPOUSE OR OTHER GUARANTOR INFORMATION (IF DIFFERENT FROM ABOVE)

Name _____ Relation _____ S.S.# _____

Address _____ Apt. _____ City _____ State _____ Zip _____

Tel. (_____) _____ Employer _____ Tel. (_____) _____

INSURANCE INFORMATION

Student..... ☐ Full-Time ☐ Part-Time ☐ Not .....School Name/Address _____

Marital Status.... ☐ Married ☐ Divorced ☐ Widow ☐ Single ☐ Separated City _____ State ____ Zip _____

Employed ..... ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Not ..... Do you belong to a PPO or HMO? ☐ Yes ☐ No

PRIMARY DENTAL INSURANCE COMPANY

Employer _____

Bus. Address _____

Bus. Tel. (_____) _____ Plan _____

Ins. Co. _____ I.D.# _____

Address _____

Tel. (_____) _____ Group _____

Insured Name _____ Group # _____

Relation _____ DOB _____ Sex ☐M ☐F

S.S.# _____ Tel. (_____) _____

Address _____

PRIMARY MEDICAL INSURANCE COMPANY

Employer _____

Bus. Address _____

Bus. Tel. (_____) _____ Plan _____

Ins. Co. _____ I.D.# _____

Address _____

Tel. (_____) _____ Group _____

Insured Name _____ Group # _____

Relation _____ DOB _____ Sex ☐M ☐F

S.S.# _____ Tel. (_____) _____

Address _____

SECONDARY DENTAL INSURANCE COMPANY

Employer _____

Bus. Address _____

Bus. Tel. (_____) _____ Plan _____

Ins. Co. _____ I.D.# _____

Address _____

Tel. (_____) _____ Group _____

Insured Name _____ Group # _____

Relation _____ DOB _____ Sex ☐M ☐F

S.S.# _____ Tel. (_____) _____

Address _____

SECONDARY MEDICAL INSURANCE COMPANY

Employer _____

Bus. Address _____

Bus. Tel. (_____) _____ Plan _____

Ins. Co. _____ I.D.# _____

Address _____

Tel. (_____) _____ Group _____

Insured Name _____ Group # _____

Relation _____ DOB _____ Sex ☐M ☐F

S.S.# _____ Tel. (_____) _____

Address _____