# NEW PATIENT INFORMATION (Confidential)

Patient Name ______________________________ Date of Birth ________________ Age ______ Gender____
Address ___________________________________ Apt _____ City _______________ State ___ Zip_________
Home Phone ________________ Cell Phone _________________ Work Phone ________________ Ext _____
Employer _________________________________ Employer Address _________________________________
Social Security No __________________________ Drivers License & State _____________________________
Email address ______________________________

**Account Responsible Party, if not patient**

Guardian __________________________________ Date of Birth ________________ Relationship___________
Address ___________________________________ Apt _____ City _______________ State ___ Zip_________
Home Phone ________________ Cell Phone _________________ Work Phone ________________ Ext _____
Employer _________________________________ Employer Address _________________________________
Social Security No __________________________ Drivers License & State _____________________________
Email address ______________________________

**Emergency Contact**

Name/Relationship ____________________________ /________________ Cell phone: ___________________
Address ___________________________________ Apt _____ City _______________ State ___ Zip_________

Insurance Information

| **MEDICAL** | **DENTAL** |
|---|---|
| Insurance Co ______________________________ | Insurance Co ______________________________ |
| Address ___________________________________ | Address ___________________________________ |
| ___________________________________ | ___________________________________ |
| Phone _____________________________________ | Phone _____________________________________ |
| Insured Party Name _________________________ | Insured Party Name _________________________ |
| ID #________________________ DOB _____________ | ID #________________________ DOB _____________ |
| Group # ____________ Employer _________________ | Group # ____________ Employer _________________ |

**Fees & Payments**

Payment is collected at time services are rendered. A pre-determination of your insurance benefits and coverage will be obtained by this office prior to any treatment. <u>However, this is based upon information received from your insurance company and is not a guarantee of payment.</u> If is your responsibility to pay any deductible amount, co insurance or any other balance not paid, or denied by your insurance company.

I hereby authorize the release of information necessary to process the claim(s). I authorize the use of this signature on all of my insurance claims, manual or electronic. I further authorize payment to Oral Surgery Associates of Paris, the benefits otherwise payable to me. I understand that I am responsible for the payment of services rendered in full, regardless of payments expected by an insurance company.

Signature ____________________________________________ Date ___________________________________

**Consent and Diagnostic Aids**

I hereby give my consent to Oral Surgery Associates of Paris for any diagnostic aids necessary to evaluate, document and diagnose my condition. These shall include, but are not limited to radiographs, models, photographs. I further give Oral Surgery Associates of Paris any medical or dental information necessary to evaluate and treat my condition.

Signature ____________________________________________ Date ___________________________________