WELCOME TO CONCORD ORAL SURGERY, P.A.

Please Take A Moment to Fill Out Our Registration Form (for any child or dependent up to age 26)

Date: _____ SS# _____

Sex: M F Date of Birth: _____ Marital Status: _____

Patient's Name: _____

Mailing Address : _____

_____

Residential Address (if different): _____

Home Phone: _____

If Student, Name of School Attending: _____

City: _____ State: _____

Mother's Name & Address: _____

Employer Name & Address: _____

Mother's Home Phone: _____ Mother's Business Phone: _____ Cell: _____

Father's Name & Address: _____

Employer Name & Address: _____

Father's Home Phone: _____ Father's Business Phone: _____ Cell: _____

Note: Any patient under the age of 18 must be accompanied by a parent or legal guardian during their time of evaluation and treatment in this office. All legal guardians must present their court documentation at the time of the initial appointment.

Please indicate, on the line below, the name of the person responsible for this bill (after insurance). This person should also be the one signing the Financial Understanding Form.: _____

Relationship: _____ Phone: _____

Address: _____

Nearest Friend or Relative: _____ Relationship: _____

Phone Number of Nearest Friend or Relative: _____

Have you or any of your family members ever been a patient at Concord Oral Surgery, P.A.? Yes No

Who is your regular dentist? _____

Who is your regular medical doctor? _____

Who referred you to Concord Oral Surgery, P.A.? _____

Disclosure information:

If you are 18 years of age or older and would like us to be able to discuss and disclose your medical care and/or billing account information with anyone other than yourself, please list below:

Name	Relationship	Telephone #

(please turn to other side...)

DENTAL INSURANCE

1st Insurance

Name of Insurance:_____

Address of Insurance: _____

Phone # of Insurance Provider: _____ Group #: _____ Id # _____

Name of Employee: _____ SS # of Employee: _____

D.O.B:_____ Effective Date of Insurance Policy: _____ *(required for billing)*
MONTH / DATE / YEAR

Employer Name & Address:_____

Relationship of Insured to Patient: _____

2nd Insurance

Name of Insurance:_____

Address of Insurance: _____

Phone # of Insurance Provider: _____ Group #: _____ Id # _____

Name of Employee: _____ SS # of Employee: _____

D.O.B:_____ Effective Date of Insurance Policy: _____ *(required for billing)*
MONTH / DATE / YEAR

Employer Name & Address:_____

Relationship of Insured to Patient: _____

• • REQUIRED FOR BILLING • •

Is there a divorce decree or other special situation that dictates how insurance should be billed? Yes_____ No_____

Per Divorce Decree please list the order that insurance should be billed:_____

_____

MEDICAL INSURANCE

1st Insurance

Name of Insurance:_____

Address of Insurance; _____

Phone # of Insurance Provider: _____ Group #: _____ Id # _____

Name of Employee: _____ SS # of Employee: _____

D.O.B:_____ Effective Date of Insurance Policy: _____ *(required for billing)*
MONTH / DATE / YEAR

Employer Name & Address:_____

Relationship of Insured to Patient: _____

2nd Insurance

Name of Insurance:_____

Address of Insurance: _____

Phone # of Insurance Provider: _____ Group #: _____ Id # _____

Name of Employee: _____ SS # of Employee: _____

D.O.B:_____ Effective Date of Insurance Policy: _____ *(required for billing)*
MONTH / DATE / YEAR

Employer Name & Address:_____

Relationship of Insured to Patient: _____