ALAMO MAXILLOFACIAL SURGICAL ASSOCIATES, PA

PATIENT INFORMATION:

Prefix *First* *Middle* *Last* *Suffix* *Preferred Name/Nickname*

Street/PO Box *City* *State* *Zip* Male/Female *(please circle)*

Home Telephone *Work Telephone* *Mobile Telephone* *Birthdate* *Age*

Social Security Number *Driver's License Number(State)* Single / Married / Divorced / Widowed *Marital Status (please circle)*

Family Physician *General Dentist* *Who Referred You To Our Practice?*

Employer Part Time/Full Time/Retired *(please circle)* *Name of School (if a student)* Part Time / Full Time *(please circle)*

Your Email Address (optional) *Emergency Contact* *Relationship to Patient* *Telephone*

RESPONSIBLE BILLING PARTY (present with patient):

Prefix *First* *Middle* *Last* *Suffix* *Preferred Name/Nickname*

Street/PO Box *Apt #* *City* *State* *Zip* Male/Female *(please circle)*

Home Telephone *Cell Telephone* *Work Telephone* *Birthdate* *Age*

Social Security Number *Driver's License Number(State)* Single / Married / Divorced / Widowed *Marital Status (please circle)*

PRIMARY MEDICAL INSURANCE:
Relationship to Patient *(please circle)* : Self / Spouse / Parent

Insurance Company *Name of Insured*

Insured's ID Number *Insured's Group Number*

Insured's SS Number *Insured's Date of Birth*

Insured's Employer *Insured's Driver's License*

SECONDARY MEDICAL INSURANCE:
Relationship to Patient *(please circle)* : Self / Spouse / Parent

Insurance Company *Name of Insured*

Insured's ID Number *Insured's Group Number*

Insured's SS Number *Insured's Date of Birth*

Insured's Employer *Insured's Driver's License*

PRIMARY DENTAL INSURANCE:
Relationship to Patient *(please circle)* : Self / Spouse / Parent

Insurance Company *Name of Insured*

Insured's ID Number *Insured's Group Number*

Insured's SS Number *Insured's Date of Birth*

Insured's Employer *Insured's Driver's License*

SECONDARY DENTAL INSURANCE:
Relationship to Patient *(please circle)* : Self / Spouse / Parent

Insurance Company *Name of Insured*

Insured's ID Number *Insured's Group Number*

Insured's SS Number *Insured's Date of Birth*

Insured's Employer *Insured's Driver's License*

I authorize payment of insurance benefits (including all Commercial, Medicare and Medigap plans) to be issued directly to Alamo Maxillofacial Surgical Assoc. for any services rendered to me. I further authorize Alamo Maxillofacial Surgical Associates to release to my insurance carrier listed above any information necessary to determine benefits payable for related services. I understand that I am responsible for payment of services not covered and/or denied by my insurance carrier and, in the event my insurance company fails to remit payment within 60 days from the date of service, I am responsible for the balance of my account. I understand a service charge of $5-$10 will apply for any balance resulting in collection activities.

Signature of Patient (or Guardian) **Date** ***Staff Intake Initials/Date***