ALAMO MAXILLOFACIAL SURGICAL ASSOCIATES, PA

PATIENT INFORMATION:						
Prefix First	Middle	Last	Last Suffix		Preferred Name/Nickname	
				Male/Female		
Street/PO Box	City	State	Zip	(please circle)		
Home Telephone	Work Telephone	Mobile	e Telephone	Birthdate	Age	
		Single / Married / Divorced / Widowed				
Social Security Number		Driver's License Numb	per(State)	Marital Status (please	circle)	
5 11 84 44		15	untiet Who		an Deferred Voy To Our Practice?	
Family Physician	Genei	ral Dentist	Wno	Who Referred You To Our Practice?		
	Part Time/Full Time/	/Patirad		Part T	ime / Full Time	
Employer	(please circ		me of School (if a student) (please circle)			
Your Email Address (optional)	Emergency Contac	ct Relatio	onship to Patient	Telepho	ne	
RESPONSIBLE BILLING PARTY	(present with patient):					
Prefix First	Middle	Last	Suffix	Preferred Na	me/Nickname	
				Male/Fen	nalo	
Street/PO Box	Apt # City	State	Zip	(please c		
Home Telephone	Cell Telephone	Work 1	elephone	Birthdate	Age	
			Single	e / Married / Divorced	/ Widowed	
Social Security Number	Driver's License Numb	Driver's License Number(State) Marital Status (please circle)				
PRIMARY MEDICAL INSURAN Relationship to Patient (please ci		SECONDARY MEDICAL INSURANCE: Relationship to Patient (please circle): Self / Spouse / Parent				
Relationship to Patient (please cr	Relationship to Fati	lent (piease circle)	. seli / spouse / Faleti	•		
Incurance Company	Name of Insured	Insurance Compar	No.	me of Insured		
Insurance Company	ivame of insured	Insurance Compar	insurance company Name of insured			
Insured's ID Number	Insured's Group Number	Insured's ID Numbe	Insured's ID Number Insured's Group Number			
	,			,		
Insured's SS Number	Insured's Date of Birth	Insured's SS Numbe	er Insi	ured's Date of Birth		
Insured's Employer	Insured's Driver's License	Insured's Employer	Insu	red's Driver's License		
PRIMARY DENTAL INSURANC	SECONDARY DE	SECONDARY DENTAL INSURANCE:				
Relationship to Patient (please ci	Relationship to Pati	Relationship to Patient (please circle): Self / Spouse / Parent				
Insurance Company	Name of Insured	Insurance Compar	ny Na	me of Insured		
Insured's ID Number	Insured's Group Number	Insured's ID Numbe	er Inst	ured's Group Number		
Insured's SS Number	Insured's Date of Birth	Insured's SS Numbe	ar Inc.	ured's Date of Birth		
insured's 33 Nutfiber	insured's Date Of Billfi	irisureu s 33 Numbe	-i ITISI	ureus Date Of Billi		
Incura d'a Employer	Incurs dia Driveria Lieure	Incurs dia Francis	I	radia Drivaria Liaana		
Insured's Employer	Insured's Driver's License	Insured's Employer		red'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.