PIEDMONT ORAL SURGERY
Patient Information
(Please Print)

PATIENT NAME

Last_____ First_____ MI_____ Name Called_____

Have you ever been a patient in this office: Yes_____ No_____ When_____

Home Address_____

City, State, Zip_____

County_____ Home Phone ( ) _____ Cell Phone ( )_____

Place of Employment or School_____ Business Phone ( )_____

Employment Address_____

Social Security No._____ Birth Date_____ Sex M_____ F_____

If Patient is a child - Person responsible for Bill_____ SS#_____

Address if different from child's_____

Is this to be filed under workers comp? If yes please give information for claims_____

_____

INSURANCE INFORMATION

	PRIMARY	SECONDARY
Insured's Name	_____	_____
Home Address	_____	_____
City, State, Zip	_____	_____
County / Home Ph. ( )	_____ _____	_____ Home Ph ( ) _____
Place of Employment	_____	_____
Employment Address	_____	_____
City, State, Zip / Bus. Ph ( )	_____ _____	_____ Bus Ph ( ) _____
Social Security No. / DOB / Sex M F	_____ _____ _____	SS#_____ DOB_____ Sex: M___ F___

INSURANCE COMPANY NAME

Medical Carrier	_____	_____
Address	_____	_____
Dental Carrier	_____	_____
Address	_____	_____

Referred By: Dentist's Name_____

PLEASE TURN OVER AND COMPLETE OTHER SIDE

HEALTH HISTORY

Physician_____

List of Medications_____

_____

Medical - Drug Allergies_____

Do you have or have you had (Circle Y or N)

1.	Heart Murmur or Other Heart Conditions	Y	N
2.	Pulmonary (lung) disease	Y	N
3.	Kidney disease	Y	N
4.	Liver disease	Y	N
5.	Diabetes	Y	N
6.	Asthma	Y	N
7.	HIV (Aids Virus)	Y	N

Previous Hospitalizations or Surgery?_____

Are you pregnant?_____

Do you have any other health problems?_____

Is visit result of accident?_____ if yes: Date of Injury_____

Description of accident_____

Address for Claims if Accident or Worker's Comp._____

_____

_____

INFORMED CONSENT AND ASSIGNMENT OF INSURANCE BENEFITS

I understand and accept the treatment as presented including any pre-operative or post-operative laboratory examinations.
The surgical procedure has been explained completely including the anesthesia to be used. I understand the risks involved with the surgery including but not limited to: Bleeding, Swelling, Soreness, Infection, Bruising, or possible numbness of the lip and chin area.
I hereby authorize assignment of Insurance Benefits for all services rendered to Piedmont Oral Surgery.
Any charge incurred to collect the account is the patient's responsibility upon non-payment.

Patient_____ Guardian_____ Date_____