Monesmith & Wood Oral & Maxillofacial Surgery, P.C.

Patient Information
(please print and sign at the bottom)

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss _____
First MI Last Nickname

Address:_____ City/State:_____ Zip:_____
Home Tel Number:_____ Work Tel Number:_____ Cell Tel Number:_____
Date of Birth ___ / ___ / ___ Age_____ Sex: ☐ Male ☐ Female
Soc. Sec. #: _____ Employer:_____
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Spouse:_____ SS#_____
Name of your Dentist:_____ Physician:_____ Orthodontist:_____
Who referred you to our office? ☐ Dentist ☐ Physician ☐ Orthodontist ☐ Friend_____ ☐ Other_____
If patient is a full time student, name of school:_____
Emergency contact:_____ Daytime Telephone Number:_____
Relationship to patient:_____

Permission to release my healthcare information to the following person(s) if necessary (i.e., spouse ,son, daughter, etc.)
_____

Is someone other than the patient responsible for this account? ☐ Yes ☐ No If yes, please complete the following information:
Name:_____ DOB:___ / ___ / ___ SSN #:_____ Home Phone:_____
Address:_____ City/State:_____ Zip:_____
Relationship to patient:_____ Occupation:_____ Work Phone:_____

DENTAL

Insurance Coverage Information
If there is additional insurance coverage, please use other side of form.

☐ Copy of card

Primary Dental Insurance
Name of insurance company:_____
Insured Name:_____ DOB ___ / ___ / ___ Insured Daytime Phone:_____
Insured Soc. Sec. #:_____ Plan ID (if other than SS#):_____
Relationship to patient:_____ Group/Account #:_____
Insurance Co. Address:_____ Employer Name:_____
_____

MEDICAL

If there is additional insurance coverage, please use other side of form.

☐ Copy of card

Primary Medical Insurance
Name of insurance company:_____
Insured Name:_____ DOB ___ / ___ / ___ Insured Daytime Phone:_____
Insured Soc. Sec. #:_____ Plan ID (if other than SS#):_____
Relationship to patient:_____ Group/Account #:_____
Insurance Co. Address:_____ Employer Name:_____
_____

Preferred Pharmacy _____ **Phone #:**_____

I understand in signing this statement that I am financially responsible for all fees incurred on my behalf, or this dependent. I agree to be responsible for all fees incurred, including any costs for collection, if necessary, including: attorney fees, court costs, collection costs, consideration for assignment, litigation expenses, or any other incidental expenses incurred by this office or our assignee(s). I authorize the release of healthcare information related to claims processing, and direct any benefits payable to me to be paid directly to the provider. I understand that Drs. Monesmith and Wood will file my insurance claim as a courtesy only and it is my responsibility to check with my insurance company concerning the benefits available to me, preferred provider status, and payment of claims.

Signed: _____ Date: _____
Patient Signature (If the patient is a minor, parent or guardian please sign)

Print name: _____