PATIENT REGISTRATION AND INSURANCE INFORMATION

Welcome to our practice. We are delighted that you have chosen us for your oral surgery needs.
Please provide us with the following information to better serve you. ***Thank you.***

Date: ____________________ Title (*please circle one*): Mr. Mrs. Ms. Miss

Patient's Full Name: ________________________________ Date of Birth: ____/____/____

Patient's Address: ________________________________

City: ________________________ State: __________ Zip: __________

Home Phone Number: ____________________ Business Number/Ext: ____________________

Cell Phone Number: ____________________ Spouse's Name: ____________________

Patient's Employer: ________________________________ Full Time? __________

Referred to us by: ____________________ Your Dentist is: ____________________

Your Medical Doctor is: ________________________________

Have you or any other family member been to see Dr. Gomez before? ____________________

Your orthodontist is: ________________________________

Emergency Contact: ____________________ Phone#: ____________________

NOTE: ***We may attempt to contact you at your business number, cell phone number and/or your home phone number. If you personally are unavailable, we will leave our name and return phone number with a brief message.***

Who will be responsible for your account? ◯ Self ◯ Parent or Legal Guardian

(If self, please skip this section.)

Name of Parent or Legal Guardian: ________________________________

Address: ________________________________

City: ________________________ State: __________ Zip: __________

Home Phone#: ____________________ Soc. Sec.# ____________________

Employer: ____________________ Business #/Ext: ____________________

If you are covered by any medical or dental insurance plans, please provide us with the following information. We will need to copy your insurance cards as well. If you do not have any medical or dental insurance, please write "none" below and skip to the next section. Thank you.

[complete other side]

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