BLUE RIDGE ORAL & MAXILLOFACIAL SURGERY

PATIENT REGISTRATION

Patient Name ____**Date**__________________________

Street Address____**Home Phone**_____________________

PO Box __________________**City**_____________________________**State**_________ **Zip Code**_________

Cell Phone________________________________**Alternate Phone**____

Date of Birth_________________**Social Security No.**_____________________**Drivers License No.**_______________

Marital Status__________**Email address**____

Dentist_______________________**Referred by**________________________**Physician**__________________________

Emergency Contact **Phone** **Relationship**

Your Employer______________________________**Work Phone**__________________________**Student** **Y** **N**

If Under the age of 18, Name of Person Responsible for Account :

Social Security No._____________________**Date of Birth**________________**Employed by**________________________

Employer Telephone No.____

FILL OUT INSURANCE INFORMATION ENTIRELY AND WE WILL FILE YOUR CLAIM ACCURATELY

	MEDICAL INSURANCE	**DENTAL INSURANCE**
Company		
Insurance Claim Mailing Address		
Subscriber Name/Address		
Subscriber SS #		
Subscriber Birth Date		
Policy ID #		
Group #		

FEES ARE DUE AT THE TIME SERVICE IS RENDERED

Updated ______________________
Updated ______________________
Updated ______________________

I authorize release of any information relating to this claim to my insurance carrier. I hereby authorize payment of the group insurance benefits directly to this practice otherwise payable to me.
I certify the above information is correct to the best of my knowledge. I also understand that I am financially responsible for all charges whether or not covered by insurance.

***Signature**____**Date**______________________________