# Commack Oral and Maxillofacial Surgery

Date _____

1.IP

**Patient:** (Mr., Mrs., Ms., Dr.) First Name _____ M.I. ____ Last Name _____ Nickname _____

Sex: ❑ Male ❑ Female Date of Birth _____ Age _____ Social Security # _____

Street _____ City _____ State _____ Zip _____

Home Tel.# ( ____ ) _____ Business Tel. # ( ____ ) _____ Ext. _____ Employer _____

Dentist _____ Medical Doctor _____ Referred By _____

e-mail _____ Nearest relative not living with you _____ Tel. # ( ____ ) _____

Have you ever been a patient of our practice? ❑ Yes ❑ No Method of Personal Payment: ❑ Cash ❑ Check ❑ Credit Card

**Who will be responsible for your account? ❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other** _____
**(If self, skip to next paragraph)**

Name _____ Soc. Sec.#: _____ Home Tel.: ( ____ ) _____

Street _____ City _____ State _____ Zip _____

Employer _____ Tel.: ( ____ ) _____

**Spouse or other guarantor information (if different from above)**

Name _____ Relation _____ Soc. Sec.#: _____ Home Tel.: ( ____ ) _____

Street _____ City _____ State _____ Zip _____

Employer _____ Tel.: ( ____ ) _____

## INSURANCE INFORMATION

1.I0

**Patient:** Student: Full Time ❑ Part Time ❑ Not ❑ School Name/Address _____

Married ❑ Divorced ❑ Legally Separated ❑ Widow ❑ Single ❑ _____

Employed: Full Time ❑ Part Time ❑ Retired ❑ Not ❑ Do you belong to a PPO or HMO? Yes ❑ No ❑

### PRIMARY DENTAL INSURANCE COMPANY

❶

**Employer** _____

Bus. Address _____

Bus. Tel.#: _____ Plan _____

1.I1 **Ins. Co. Name** _____

Address _____

_____ Phone:( ____ ) _____

**Group # :** _____ **Group Name:** _____

Insured Party _____ Relation _____

Sex: ❑ M ❑ F Date of Birth: _____

Street: _____

City, State, Zip: _____

Phone: _____ S.S.#: _____

I.D.#: _____

### PRIMARY MEDICAL INSURANCE COMPANY

**Employer** _____

Bus. Address _____

Bus. Tel.#: _____ Plan _____

**Ins. Co. Name** _____

Address _____

_____ Phone:( ____ ) _____

**Group # :** _____ **Group Name:** _____

Insured Party _____ Relation _____

Sex: ❑ M ❑ F Date of Birth: _____

Street: _____

City, State, Zip: _____

Phone: _____ S.S.#: _____

I.D.#: _____

### SECONDARY DENTAL INSURANCE COMPANY

❷

**Employer** _____

Bus. Address _____

Bus. Tel.#: _____ Plan _____

1.I1 **Ins. Co. Name** _____

Address _____

_____ Phone:( ____ ) _____

**Group # :** _____ **Group Name:** _____

Insured Party _____ Relation _____

Sex: ❑ M ❑ F Date of Birth: _____

Street: _____

City, State, Zip: _____

Phone: _____ S.S.#: _____

I.D.#: _____

### SECONDARY MEDICAL INSURANCE COMPANY

**Employer** _____

Bus. Address _____

Bus. Tel.#: _____ Plan _____

**Ins. Co. Name** _____

Address _____

_____ Phone:( ____ ) _____

**Group # :** _____ **Group Name:** _____

Insured Party _____ Relation _____

Sex: ❑ M ❑ F Date of Birth: _____

Street: _____

City, State, Zip: _____

Phone: _____ S.S.#: _____

I.D.#: _____