GPC | ORAL & FACIAL SURGERY CENTER

PATIENT INFORMATION *(Please Print)*

Name | Social Security #

Home Telephone # | Work Telephone #

Address

Email Address

Sex: Male / Female Age Birth Date | Single / Married / Separated / Divorced / Widowed

Patient Employed By | Occupation:

Business Address

If Patient is a full-time student, name of school / college / university

School / College / University Address

In case of an emergency, please notify | Telephone #

Is this visit due to an accident? Yes / No Date of accident | Work-related? Yes / No | Motor Vehicle? Yes / No

Please describe accident

INSURANCE INFORMATION *(Please provide insurance cards to the Receptionist)*

Dental Insurance Carrier | Group #

Address | ID #

Insured Member's Name | Birth Date | Social Security #

Insured Member's Address | Telephone #

Employed by | Telephone #

Employer's Address

What is the Patient's relationship to insure member? Self / Spouse / Child / Other

Primary Dentist Name / Address

Does your dental insurance require a referral or prior authorization? Yes / No

If yes, have you contacted your primary dentist for a referral? Yes / No

Medical Insurance Carrier | Group #

Address | ID #

Insured Member's Name | Birth Date | Social Security #

Insured Member's Address | Telephone #

Employed by | Telephone #

Employer's Address

What is the Patient's relationship to insure member? Self / Spouse / Child / Other

Primary Care Physician's Name / Address | Telephone #

Does your medical insurance require a referral or prior authorization? Yes / No

If yes, have you contacted your primary physician for a referral? Yes / No

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to GPC Oral & Facial Surgery Center otherwise payable to me. I authorize the Providers to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance and that preauthorization of benefits does not guarantee payment. I authorize the use of this signature on all insurance submissions. I agree that I am responsible for all fees incurred if my account is turned over to a third party collector.

Patient/Parent's Signature (if patient s under the age of 18) | Date

*If parent signing is different from insured member | Birth Date | Social Security #

Home telephone # | Work Telephone #