Patient Name ______________________________________ Date of Birth ___________ Age ______

Social Security # __________________ Marital Status S ___ M ___ W ___ D ___ Sex Male ___ Female ___

Home Address ______________________________ City ______________ State _____ Zip _______

Phone Numbers: Home # ___________ Cell # ___________ Work # __________ Message # __________

Employer ___________________________ Address ______________________________________

Full-Time ________ Part-Time ________ College Student - Name of College ______________________

Emergency Contact Name ____________________ (relationship) ________________ Phone # ________

(If under 18 years of age) Name of Legal Guardian ____

Address of Guardian ____ Phone # ________________

Policy Holder's Name ___________________________ Relationship to Patient __________________

Policy Holder's Date of Birth ___________________________ S.S.# ______________________________

Policy Holder's Employer _________________________________ Phone # _____________________

Employer's Address ____

MEDICAL INSURANCE INFORMATION

Primary Insurance ______________________________ Address ______________________________

Policyholder's Name ______________________________________ Relationship ___________________

Identification # or SS # ____________________________________ Group/Policy # ________________

Secondary Insurance ____________________________ Address ______________________________

Policyholder's Name ______________________________________ Relationship ___________________

Identification # or SS # ____________________________________ Group/Policy # ________________

DENTAL INSURANCE INFORMATION

Primary Insurance ______________________________ Address ______________________________

Policyholder's Name ______________________________________ Relationship ___________________

Identification # or SS # ____________________________________ Group/Policy # ________________

Secondary Insurance ____________________________ Address ______________________________

Policyholder's Name ______________________________________ Relationship ___________________

Identification # or SS # ____________________________________ Group/Policy # ________________

INJURY/ACCIDENT INSURANCE

Injury/Accident related to: Motor Vehicle: ____ Workman's Comp ____ Other Accident ____ Date of Injury _______

Insurance Name ___________________________________ Address ____________________________

Claim # __________________________________ Agent ___________________ Phone # ____________

AUTHORIZATION AND ASSIGNMENT

All professional services rendered are charged to the patient. The patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office. I hereby authorize J.W. Rice Oral Maxillofacial and Aesthetic Facial Surgery, P.C. to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the physician(s) all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by insurance.

Date: ____________ Signature: ______________________________ Relationship __________________