Centre Oral & Facial Surgery, P.C. Dr. Greg Kewitt

Patients Legal Name: ____________________
(First) (Middle Int.) (Last) Preferred name

Address: ____________________
City, ST Zip: ____________________
Home Phone/Cell: ____________________
Birth Date: ____________________ Age: __________
S.S. # ____________________
Marital Status *(circle)*: Single / Married / Divorced / Widowed

Email: ____________________

Employer: ____________________
Occupation: ____________________
Work Phone: ____________________

Students only: _____Full Time _____Part Time
Name of School: ____________________
Local Address (if different): ____________________
____

Person Responsible for Account: _____Self (if self, skip this section) _____Spouse _____Parent ______Other (specify)________

Responsible Party's Name: ____________________
Address: ____________________ City, ST Zip: ____________________
Home Phone/Cell: ____________________ Birth Date: ____________ S.S. #: ____________
Employer: ____________________ Occupation: ____________________
Employer Phone Number: ____________________

Other than the above, is there another adult responsible for this account? Yes______ No ______

Emergency Contact / HIPAA disclosure authorization: Name: ____________________
Relationship to Patient: ____________________ Phone # that they may be reached: ____________________

Physicians:

Referred by: ____________________ Telephone #: ____________________
General Dentist: ____________________ Telephone #: ____________________
Orthodontist: ____________________ Telephone #: ____________________
Family Physician: ____________________ Telephone #: ____________________

In order to file insurance, please provide insurance cards and complete the following sections:

Medical Insurance Company Name: ____________________ Telephone: ____________
Primary Insured's Name: ____________________ Birth Date: ____________ SS #: ____________
Employers Name: ____________________
Group # ____________ Policy /I.D. # ____________________
Relationship to Patient: ____________________
Do you have secondary medical? *Yes*______ *No* ______

Dental Insurance Company Name: ____________________ Telephone: ____________
Primary Insured's Name: ____________________ Birth Date: ____________ SS #: ____________
Employers Name: ____________________
Group # ____________ Policy /I.D. # ____________________
Relationship to Patient: ____________________
Do you have secondary dental? *Yes*______ *No* ______

Authorization, release& agreement to pay for services rendered.

I authorize the doctor and other dentists or health-care professionals to perform diagnostic procedures and treatment as may be necessary for proper dentofacial care. I authorize the taking of photographs, radiographs and other diagnostic records before, during and after treatment and to use the same by the doctor in scientific presentations or scientific literature. I authorize **Centre Oral & Facial Surgery, P.C.** and its credentialed providers to release any information (via mail, fax or electronically) including the diagnosis and the records of any treatment or examination rendered to me/my child during the period of such Dental/Medical care to third party payors, and other entities and/or health practitioners. I authorize and hereby request my insurance company to pay directly to Centre Oral & Facial Surgery insurance benefits otherwise payable to me. I understand that my dental and or medical insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

____________________ ____________________ ____________
Signature of Patient **Signature of Guardian (if minor)** **Date**

This copy of signature is valid as the original. Signature on file is valid indefinitely.