CHERRY TREE ORAL AND MAXILLOFACIAL SURGERY

PATIENT INFORMATION (PLEASE SIGN AT THE BOTTOM)

PATIENT NAME____________________NICKNAME____________ DATE ____________

ADDRESS____________________ CITY______________ ST_______ ZIP____________

HOME #____________CELL#____________WK#____________EMAIL______________

BIRTHDATE__________ AGE________ SEX: M☐ F☐ SSN (*Required if you are 18 or older*) ______________
Student: PT☐ FT☐ Marital Status: Single☐ Married☐ Widowed☐ Divorced☐

DL#______________EMPLOYER/SCHOOL name & address______________________

DENTIST____________PHYSICIAN____________ORTHODONTIST______________

EMERGENCY CONTACT______________________PHONE____________________

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT

NAME________________________RELATIONSHIP TO PATIENT________________

HOME ADDRESS______________CITY__________STATE________ZIP__________

HOME #______________CELL#______________WK#______________

DATE OF BIRTH__________ SEX: M☐ F☐ SOCIAL SECURTIY NUMBER______________
(Required Information)

EMAIL______________________ DL#______________________

EMPLOYER______________________ ADDRESS______________________

By providing my cell number and e-mail, I give prior express consent to receive calls, e-mails and text messages from the creditor, or its third party debt collector at this number and e-mail address; including call, e-mails and messages by using an auto-dialer or prerecorded message.

DENTAL INSURANCE INFORMATION

(Person carrying insurance on this patient)

INSURED NAME______________________INSURED ADDRESS______________________

INSURED DOB__________INSURED PHONE #__________INSURED SOC. SEC. #______________

EMPLOYER NAME/ADDRESS______________________________________

NAME OF INSURANCE COMPANY______________________________________

INSURANCE ADDRESS______________________________________

PLAN ID(if other than SS#)______________________GROUP#______________________

INSURANCE CO. PHONE #______________RELATIONSHIP TO PATIENT______________

SECONDARY DENTAL/ OR MEDICAL INSURANCE INFORMATION DENTAL☐ MEDICAL☐

INSURED NAME______________________INSURED ADDRESS______________________

INSURED DOB__________INSURED PHONE #__________INSURED SOC. SEC. #______________

EMPLOYER NAME/ADDRESS______________________________________

NAME OF INSURANCE COMPANY______________________________________

INSURANCE ADDRESS______________________________________

PLAN ID(if other than SS#)______________________GROUP#______________________

INSURANCE CO. PHONE #______________RELATIONSHIP TO PATIENT______________

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Dr. Cowan all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

X______________________________ ______________

PERSON FINANCIALLY RESPONSIBLE SIGNATURE DATE