



PRAIRIE
Oral Surgery
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Patient Registration Form

Patient's Name _____ **Today's Date:** _____
Last First MI

DOB: _____ / _____ / _____	Age: _____	Soc. Security Number: _____ / _____ / _____
Male / Female (Please circle one)		Driver's License No. _____
Address: _____		Marital Status: Single Married Divorced (Please circle one)
City: _____ State: _____ Zip: _____		Home telephone: _____
Cell /other telephone: _____		Spouse's Name: _____
Patient (or Parent) Employer: _____		Spouse's Employer: _____
Employer's Phone: _____		Referring Doctor's Name: _____

Responsible Party: (If different from patient or if patient is a minor)

Name: _____	Relationship to Patient: _____
<small>Last First MI</small>	
Address: _____	Social Security No: _____
<small>Street City State Zip</small>	
Home Phone: _____	Work: _____ Employer: _____ Phone: _____

Emergency Contact:

Contact Person not living with you: Name: _____	Phone: _____
Relationship to Patient: _____	

If Accident Related:

Insurance Co. _____	Phone: _____
Co. Address: _____	
Date of Injury: _____	Description of Accident: _____
Policy Holder: _____	Benefits Available: _____

Please continue on the back of this page.

Insurance Information:

DENTAL

<u>Primary DENTAL Insurance Coverage Information:</u>	<u>Secondary DENTAL Insurance Coverage Info:</u>
Name of Insurance Co. _____	Name of Insurance Co. _____
Co. Address: _____	Co. Address: _____
Co. Phone: _____	Co. Phone: _____
Plan/I.D. # _____	Plan/I.D. # _____
Policy Holder's Name: _____	Policy Holder's Name: _____
Policy Holder's Date of Birth: _____	Policy Holder's Date of Birth: _____
Policy Holder's Soc Sec # _____	Policy Holder's Soc Sec # _____
Policy Holder's Employer _____	Policy Holder's Employer _____

MEDICAL

<u>Primary MEDICAL Insurance Coverage Information:</u>	<u>Secondary MEDICAL Insurance Coverage Info.:</u>
Name of Insurance Co. _____	Name of Insurance Co. _____
Co. Address: _____	Co. Address: _____
Co. Phone: _____	Co. Phone: _____
Plan/I.D. # _____	Plan/I.D. # _____
Policy Holder's Name: _____	Policy Holder's Name: _____
Policy Holder's Date of Birth: _____	Policy Holder's Date of Birth: _____
Policy Holder's Soc Sec # _____	Policy Holder's Soc Sec # _____
Policy Holder's Employer _____	Policy Holder's Employer _____

Release of Information for Routine Care & Notice of Privacy Practices

The following release will allow us to share pertinent information regarding your care to enhance your treatment and/or financial reimbursement for services received:

1. I authorize Prairie Oral Surgery to share information regarding my course of treatment and the services received with my referring medical and dental providers in order to enhance my continuing treatment and care.
2. I authorize Prairie Oral Surgery and/or any other provider or supplier of services in this office to release any information required to secure payment for services received or the payment of benefits on my behalf. I authorize the use of this signature on all insurance submissions.
3. I hereby authorize payment directly to Prairie Oral Surgery for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether paid or not by insurance, and for all services rendered on my behalf or on behalf of my dependents.
4. I have had the opportunity to review this office's Notice of Privacy Practices.

Signed _____ Date _____
 (Patient - Parent or Guardian, if minor)