Patient's Name: _____ DOB: _____ Age: _____ Sex: _____

Physical Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____ Work: _____

Marital Status: _____ SSN#: _____ Occupation/Employer: _____

Dentist Name: _____ Medical Doctor: _____

Are you currently receiving orthodontic care? _____ Orthodontist: _____

Pharmacy (name, address, phone number):

_____

Explain in your own words why we are seeing you today: _____

EMERGENCY CONTACT:

Contact: _____ Relationship: _____

Home Phone: _____ Cell: _____ Work: _____

Contact: _____ Relationship: _____

Home Phone: _____ Cell: _____ Work: _____

Signature of Patient/Guardian: _____ Date: _____

Guarantor Information

The guarantor is the insured and/or financially responsible party.

Port Royal Oral Surgery is more than willing to assist you in filing your insurance claims. Insurance cards must be presented at reception if you choose for us to verify benefits and/or file your claims.

It is the patient's responsibility to give us all current insurance cards and necessary information.

Dental Insurance Information: *(Policy Holder's information.)*

Policy Holder Name: _____ Insurance Name: _____

DOB: _____ SSN: _____ ID Number: _____

Relationship to Patient: _____

Medical Insurance Information: *(We are not Medicare/Medicare supplement providers and are unable to bill for any procedure.)*

Policy Holder Name: _____ Insurance Name: _____

DOB: _____ SSN: _____ ID Number: _____

Relationship to Patient: _____

Who will be responsible for this account? Self ____ Spouse ____ Mother ____ Father____ Other ____

Name: _____ DOB: _____ SSN: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Home Phone: _____ Cell: _____ Work: _____

Email _____

Please note: Account holders will be responsible for any outstanding balance on the account. By signing below you take full responsibility of any overdue balance and may be sent to collections after 90 days with a 30% collections fee.

ASSIGNMENT AND RELEASE OF BENEFITS

I hereby authorize payment directly to the doctors and/or Oral Surgeons for any & all services rendered. I fully understand that I will be financially responsible for any unpaid and/or non-covered services. I also give my authorization to the physician to release any information required in order to process the claim or for any other reason deemed necessary.

Signature of Guarantor/Financially Responsible: _____ Date: _____