Sarasota Oral & Implant Surgery

ORAL MAXILLOFACIAL SURGERY | DENTAL IMPLANTS | BOARD CERTIFIED

2130 South Tamiami Trail | Sarasota, Florida 34239 | (941) 365-3388 | Fax (941) 954-0521

Confidential Patient Information

Name: Dr. / Mr. / Mrs. / Ms. ______________________ ❑ M ❑ F Date: __________
(please circle) (Last) (First) (MI) (Nickname)

Billing/Mailing Address: ______________________
(Street) (City / State) (Zip)

Physical Address: ______________________
(Street) (City / State) (Zip)

Home Phone: __________ Cell Phone: __________ Birthdate: __________ Age: ______ SS # __________

E-mail Address: ______________________

Marital Status: __________ Employer / Student: __________

Preferred Contact Phone #: __________ Which is: Self / Mom / Dad or Other: __________

Emergency Contact – Name: __________ Phone: __________ Relationship: __________

<u>For Children</u>:

Father's Name: __________ Phone: __________

Mother's Name: __________ Phone: __________

Have you or a family member been a patient in this office before? ❑ Yes ❑ No ❑ Family Member

Name of Family Member: __________ When: __________

Whom may we thank for referring you to our office? __________

General Dentist: __________ Orthodontist: __________

Medical Doctor: __________ Phone: __________

Cardiologist: __________ Phone: __________

Pharmacy Name: __________ Location: __________ Phone: __________

Financially Responsible Party

Please check one: ❑ Self ❑ Spouse ❑ Parent ❑ Guardian ❑ Benefactor ❑ Power of Attorney

Name: Dr. / Mr. / Mrs. / Ms. ______________________ ❑ M ❑ F Marital Status: __________
(please circle) (Last) (First) (MI) (Nickname)

Address: ______________________
(Street) (City / State) (Zip)

Home Phone: __________ Cell Phone: __________ Birthdate: __________ Age: ______ SS # __________

I understand that unless other arrangements have been made prior, all fees are due in full the day the service is rendered. I authorize Sarasota Oral and Implant Surgery to disclose pertinent medical / dental information to my insurance company when indicated to facilitate a claim.

Signature of Patient (If a minor, signature of legal guardian): ______________________ Date: __________

Updates (Date and Initial): ______________________

Sarasota Oral & Implant Surgery
ORAL MAXILLOFACIAL SURGERY | DENTAL IMPLANTS | BOARD CERTIFIED
2130 South Tamiami Trail | Sarasota, Florida 34239 | (941) 365-3388 | Fax (941) 954-0521

Dental Insurance Information

If you have dental insurance we will be happy to send a claim to your dental insurance provider on your behalf. In order to do so we will need all the below information filled out. We will also need a copy (front and back) of your dental insurance card. If your dental insurance is under your Medical Insurance, you will need to call them to get the Dental Claims address. We are out of network with all Insurance providers (Medical and Dental) but we will send a dental claim if you provide us with all the information needed. Note: We cannot send Dental Claims to your Medical Insurance.

Dental Insurance? Yes ☐ No ☐

Dental Insurance Company:____

Policy # / ID # / Member #: ____

Group #: ____

Subscriber's Name / Primary Person:____________________________________

DOB:____________________SS#: ________________________________

– Reminder that all payment is due at the time of service –

– We do not accept insurance as a form of payment –