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:** __________

For Children:

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: __________

Dental Insurance? Yes ❑ No ❑ Insurance Company: __________ ID#: __________

Subscriber's Name / Primary Person: __________ DOB: __________ SS#: __________

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): ______________________