Prather Oral & Facial Surgery

Patient Information

Today's Date:_____ Your Age:_____ Sex: Male_____ Female_____

Who referred you to this office? _____ Dentist Name:_____

First Name MI Last Name Nickname

Address_____City_____State_____Zip Code_____

Home Number:_____Work Number:_____Cell Number:_____

Date of Birth:_____Patient Social Security#:_____Occupation:_____

Employed By:_____Address:_____

Marital Status: S M D W

Emergency Contact:_____Phone:_____

Insurance Information

Primary Dental:_____ **Secondary Dental**:_____

Subscriber Name:_____ **Subscriber Name**:_____

ID/SSN#:_____**DOB**_____ **ID/SSN#**:_____**DOB**_____

Relationship to Patient:_____ **Relationship to Patient**:_____

Primary Medical:_____ **Secondary Dental:**_____

Subscriber Name:_____ **Subscriber Name:**_____

ID/SSN#:_____**DOB**_____ **ID/SSN#:**_____**DOB**_____

Relationship to Patient:_____ **Relationship to Patient:**_____

Communication Consent Form

Method	Phone Number	OK to leave a message with information?	
___Home Phone	(___)_____	__YES	__NO
___Cell Phone	(___)_____	__YES	__NO

_____ _____

Patient or Legal Guardian/Representative Signature Date