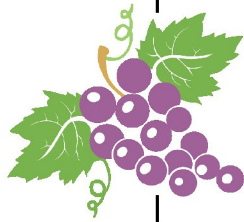

Simmonds, Brady & Loi

ORAL & MAXILLOFACIAL SURGERY
AND IMPLANT SPECIALISTS, P.C.

PATIENT INFORMATION SHEET

Today's Date: _________________

Patient's Name: ____ Weight: ____________ lbs
Last First Mi

Date of Birth: ____/____/____ Age: _____ Social Security#: ___________________________
Address: ____
Street City State Zip
Home Phone #: (____)____________________ Business Phone #: (____)_________________
Place of Employment: ____
Parent/Spouse Name: ______________________________ Date of Birth: ________________

Dentist: ____________________________________ Phone #: __________________________
Physician: __________________________________ Phone #: __________________________
Pharmacist: _________________________________ Phone #: __________________________
Referred by: _________________________________

Insurance Company Name: ____
Address: ____
Subscriber Name: _____________________ Date of Birth: ______________________
Subscriber ID#: _______________________ Group #: _________________________

Secondary Insurance Company Name: ____
Address: ____
Subscriber Name: _____________________ Date of Birth: ______________________
Subscriber ID #: _______________________ Group #: _________________________

Person Responsible for Payment: ____
Address: ____
Date of Birth: _______________________ Social Security #: ____________________
Home Phone: _______________________ Business Phone #: ____________________

I understand that insurance may not cover the entire amount due. I realize that I am responsible for ALL charges on the date of service. All unpaid invoices are subject to finance charges of 18%. I understand that I am responsible for all collection/legal fees incurred as a result of any unpaid invoices. I state that I read, write and understand English.

____
Signature of Responsible Party Date