AURORA DENTAL SPECIALISTS

WILLIAM L. PERKINSON, D.D.S.

ORAL AND MAXILLOFACIAL SURGERY

Date _____

PATIENT INFORMATION

Name _____ Wishes to be called _____

Birthdate _____ Soc Sec# _____

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married Height _____ Weight _____

Address _____ City, State, Zip Code _____

Home # _____ Cell # _____ Work # _____ Ext _____

Where do you prefer to receive calls? ☐ Home ☐ Cell ☐ Work

E-mail Address _____ Referred by _____

My Dentist is _____

PERSON RESPONSIBLE FOR ACCOUNT

Name _____ Relationship to patient _____

Birthdate _____ Soc Sec # _____

Home Phone _____ Cell Phone _____ Work phone _____ Ext _____

Address _____ City, State, Zip Code _____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance

Insurance Company _____

Group # _____

Name of Insured _____

Employer _____

Relationship to Patient _____

Insured DOB _____ Ins ID# _____

Secondary Dental Insurance or Medical PPO

Insurance Company _____

Group # _____

Name of Insured _____

Employer _____

Relationship to Patient _____

Insured DOB _____ Ins ID# _____

All of the above information is correct. I understand that I am responsible for all costs of dental treatment. I authorize release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or other health practitioners. I hereby authorize payment directly to Aurora Dental Specialists of the insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____

SIGNATURE OF PATIENT OR GUARDIAN

_____

SIGNATURE OF INSURED PERSON OR PARTY