Advanced Oral and Facial Surgery, Inc.
Oral and Maxillofacial and Facial Cosmetic Surgery

Patient ID #: __________
Patient Information

Name: ***Mr. / Mrs. / Ms. / Dr.*** ______________________________ S M W D Separated
First Middle Initial Last Marital Status (Circle One)

Date of Birth: ______________ Age: ________ Sex: ________ Social Security #: ______________

Home Address: ____
Street City, State Zip

Home Phone #: (___) ______________ Work Phone #: (___) ______________ Cell #: (___) ______________

Employer / School (if student): ________________________________

Physician's Name: ______________ General Dentist's Name: ______________

Who referred you to our office? ______________ If not referred, how did you find out about us? ______________

Person legally responsible for account: ______________ Relationship to patient: ______________

Address (if different than patients): ________________________________
Street City, State Zip

Social Security #: ______________ Driver's license #: ______________ State Issued: __________
Please give license to front so a photocopy can be made

Home #: (___) ______________ Work Phone #: (___) ______________ Employer: ______________

INSURANCE INFORMATION

Medical Insurance Co: ______________ Policy Holder's Name: ______________ DOB: ________

SS# or ID#: ______________ Group #: ______________

Dental Insurance Co: ______________ Policy Holder's Name: ______________ DOB: ________

Relation to Patient: ______________ Policy Holder's Employer: ______________

SS# or ID#: ______________ Group #: ______________

Please note: ***Fees for all services are to be paid in full (cash, check, or charge) at the time of service.***

Emergency Contact

(Please list relative or friend not living with you)

Name: ______________________________ Relationship: ______________

Home Phone #: (___) ______________ Work Phone #: (___) ______________

Friday appointments are a premium appointment and patient payment is required prior to scheduling an appointment. We require a 48 hour notice on all scheduled appointments. If you are unable to make your appointment and 48 hrs notice is not given or you miss your appointment you will be required to pay a $150.00 late notice/no show fee prior to rescheduling your appointment.

______________ ______________________________
Date **Patient, Parent or Guardian's Signature**