Ellis Oral & Maxillofacial Surgery Implants & Lilly

Thank you for choosing our office to serve your Oral Surgery needs. We will strive to provide you with the best possible surgical care. Please fill out this form as completely as possible. This will assist us in doing our best to help you. Please feel free to ask any questions or seek assistance if you need any help filling out these pages. ***Thank you!***

Today's Date _____

Patient Name _____ ☐M ☐F **Date of Birth**_____
First **M.I.** **Last**

If Child, Parent or Legal Guardian Name _____

SSN of Parent Signing this Form for Minor Patient _____

Name patient wants to be called _____ ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐Minor

Home Address:
Street _____**Apt #**_____**City**_____ **State** ____ **ZIP** _____

Home Phone _____**Work or Cell Phone** _____

SSN Patient _____

Patient/Parent Employer _____ **Spouse's Name** _____

Driver's License # _____ **State** ____ **If Military (or dependent), Rank of service member**_____

Patient's Dentist _____ **Patient's Physician** _____

SOMEONE TO NOTIFY IN CASE OF EMERGENCY WHO DOES NOT LIVE WITH YOU: (*required*)

_____**PHONE**_____

If you are a student what school do you attend? _____

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DENTAL INSURANCE

SUBSCRIBER NAME _____ **SUBSCRIBER DATE OF BIRTH** _____

EMPLOYER _____**SUBSCRIBER SSN/ID #** _____

NAME OF INSURANCE CO. _____

MEDICAL INSURANCE (If different from above)

SUBSCRIBER NAME _____ **SUBSCRIBER DATE OF BIRTH** _____

EMPLOYER _____**SUBSCRIBER SSN/ID #** _____

NAME OF INSURANCE CO. _____

PLEASE READ & SIGN THE STATEMENT IN THE BOX BELOW:

Release: I authorize the Oral Surgeon to perform diagnostic procedures and treatment that may be necessary for proper surgical care. I authorize release of any information concerning my care, or my child's health care, advice or treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorized release of any information concerning my care or my child's, health care, advice or treatment to another health practitioner. I hereby authorize payment of insurance benefits directly to Clarksville OMS, PLLC that would otherwise be payable to me for these services. I understand that my dental or medical insurance carrier may pay less than the actual bill for services. I understand that I am financially responsible for payments in full of all accounts. If collection action is taken, I agree to pay all charges for services, additional collection costs (35%), attorney fees and possible court costs. By signing this statement I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid in whole or in part by my dental or medical insurance or payer. I also attest to the accuracy of the information I have entered on this page.

Patient or Guardian Signature _____ Date _____