St. Augustine Oral & Facial Surgical Center

(PLEASE COMPLETE IN FULL; INK PEN ONLY)

PATIENT'S Legal Name:_____ Nickname: _____
(first) (middle) (last)

Address:_____
(no & street) (city) (state) (zip)

Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐

Birth date:_____ Age:_____ Sex:_____ SS# _____

If Student: Full-time:___ Part-time:____ School:_____

Employer:_____ Occupation:_____

Home #_____ Cell #_____ Work #_____ E-Mail_____

Family Members Treated by Dr. Johnson**:**

GUARANTOR (If different from patient) **Name:**_____

Birth date:_____ SS#_____ Marital Status: _____

Address: (if different)_____
(no & street) (city) (state) (zip)

Employer:_____ Relation to Patient:_____

Home # (if different):_____ Cell #_____Work #_____ E-Mail_____

PHYSICIANS: (Full name please)

Referred by:_____ Orthodontist:_____

General Dentist:_____ Family Physician:_____

PREFERRED PHARMACY:

Name:_____ Location:_____

EMERGENCY CONTACT

Name: _____ Relation to Patient: _____

Home #_____ Cell #_____ Work #_____ E-Mail _____

DENTAL INSURANCE:

Ins. Company:_____ Phone # _____

Insured's Name:_____ Birth date:_____ Relation to Patient: _____

Ins. Address:_____

S.S.#_____ Policy/Certificate #_____

Employer's Name:_____ Group #_____

Do you have secondary dental/medical? If so please inform

MEDICAL INSURANCE:

Ins. Company: _____ Phone # _____

Ins. Address:_____

Insured's Name: _____ Birth date:_____ Relation to Patient: _____

SS#:_____ Policy/Certificate #_____

Employer's Name:_____ Group #_____

AUTHORIZATION, RELEASE & AGREEMENT TO PAY FOR SERVICES RENDERED.

I authorize the doctor and other dentists or health-care professionals (interdisciplinary team members) to perform diagnostic procedures and treatment as may be necessary for proper dental-facial care. I authorize the taking of photographs, radiographs and other diagnostic records before, during and after treatment and to use the same by the doctor or interdisciplinary team members in scientific presentations or scientific literature. I authorize **St. Augustine Oral and Facial Surgery Center** to release any information (via mail, fax, phone, or email) including the diagnosis and the records of any treatment or examination rendered to me/my child during the period of such Dental/Medical care to third party payers, and other entities and/or health practitioners. 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 on behalf of my dependents.

_____ _____ _____

Signature of Patient **Signature of Guardian (if minor)** **Date**

This copy of signature is valid as the original. Signature on file is valid indefinitely

Rev. 12/28/2017