



Tri-State Oral and Facial Surgery

DATE

Michael D. Couchot, DMD, MD

NEW UPDATE

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, MI)		AGE	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH	HOME TELEPHONE
ADDRESS (STREET, APT NO.)		EMPLOYER/SCHOOL		TELEPHONE	
CITY	STATE	ZIP	EMPLOYER/SCHOOL ADDRESS		CITY STATE
MARITAL STATUS	SOCIAL SECURITY #	EMPLOYMENT STATUS <input type="checkbox"/> Full-time <input type="checkbox"/> Retired <input type="checkbox"/> Part-time <input type="checkbox"/> Not Employed		PATIENT STUDENT STATUS if 19 Years or Older <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Not a Student	
FAMILY PHYSICIAN	DENTIST	REFERRING DOCTOR		REASON FOR VISIT	
PLEASE LIST SOMEONE WE MAY CALL IN CASE OF EMERGENCY WHO DOES NOT LIVE IN THE SAME HOUSEHOLD				WHO MAY WE THANK FOR THIS REFERRAL:	

RESPONSIBLE PARTY FOR BILLING (IF DIFFERENT THAN PATIENT)

RESPONSIBLE PARTY NAME (LAST, FIRST, MI)		RELATIONSHIP TO PATIENT	DATE OF BIRTH	SOCIAL SECURITY #
RESPONSIBLE PARTY ADDRESS		EMPLOYER NAME		TELEPHONE
CITY	STATE	ZIP	EMPLOYER ADDRESS	
TELEPHONE (HOME)	TELEPHONE (EMERGENCY)	CITY	STATE	ZIP

INSURANCE INFORMATION

DENTAL INSURANCE

MEDICAL INSURANCE

SECONDARY INSURANCE

INSURANCE COMPANY NAME		INSURANCE COMPANY NAME		INSURANCE COMPANY NAME	
SUBSCRIBER NAME ON INSURANCE CARD		SUBSCRIBER NAME ON INSURANCE CARD		SUBSCRIBER NAME ON INSURANCE CARD	
EMPLOYER		EMPLOYER		EMPLOYER	
DATE OF BIRTH	RELATIONSHIP TO PATIENT	DATE OF BIRTH	RELATIONSHIP TO PATIENT	DATE OF BIRTH	RELATIONSHIP TO PATIENT
POLICY ID NUMBER	GROUP NUMBER	POLICY ID NUMBER	GROUP NUMBER	POLICY ID NUMBER	GROUP NUMBER
INSURANCE CLAIM ADDRESS (Street, Suite no.)		INSURANCE CLAIM ADDRESS (Street, Suite no.)		INSURANCE CLAIM ADDRESS (Street, Suite no.)	
CITY	STATE	ZIP	CITY	STATE	ZIP
TELEPHONE		TELEPHONE		TELEPHONE	

Tri-State Oral and Facial Surgery is hereby authorized to give my insurance company or its representatives, any and all information they may have regarding my or my dependent's condition when under observation or treatment by them, including history obtained, diagnosis and treatment. A photocopy of my signature may be used. I hereby assign the benefits payable under my insurance to Tri-State Oral and Facial Surgery.

LEGAL SIGNATURE: _____ DATE: _____

I request that payment of authorized Medicare benefits be made on my behalf to Tri-State Oral and Facial Surgery for any services furnished me by the physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

SIGNATURE: _____ DATE: _____