Lewis D. Gilbert, DDS, Ltd.

Oral & Maxillofacial Surgery

www.DrGsmilesurgery.com

PATIENT INFORMATION SHEET

(ALL INFORMATION WILL BE HELD IN STRICT CONFIDENCE)

Patient Name: _____

Home Mailing Address: _____

_____

Home Physical Address: _____

_____

Home Phone: _____ **Cell:** _____

Employer Name: _____

Date of Birth: _____**Sex: Male** ___ **Female** ___

Social Security Number: _____

Drivers License Number: _____

Marital Status: _____ **Single** _____ **Separated**

_____ **Married** _____ **Widowed**

_____ **Divorced**

Is patient a full time student? _____**Yes** _____ **No**

Name & address of school: _____

Emergency Contact: _____

Relationship to Patient: _____ **Phone:** _____

Parent/Spouse Information

	Mom/Spouse	Dad
Name:		
Address:		
Phone:		
Alternate Phone:		
Date of Birth:		
Social Security:		
Employer:		

This signature is my authorization for the release of medical and financial information necessary for this office.

***Signature:** _____

Insurance Information

Primary Medical Insurance

Name of Insurance: _____

Subscriber Name: _____

Relationship to Patient: _____

Subscriber Date of Birth: _____

Subscriber Social Security Number: _____

Subscriber Address (if different from above**):** _____

_____

Employer's Name: _____

Employer's Address: _____

_____

Employer's Phone: _____

Primary Dental Insurance

Name of Insurance: _____

Subscriber Name: _____

Relationship to Patient: _____

Subscriber Date of Birth: _____

Subscriber Social Security Number: _____

Subscriber Address (if different from above**):** _____

_____

Employer's Name: _____

Employer's Address: _____

_____

Employer's Phone: _____

Referring Doctor or Dentist: _____

After providing copies of all of your insurance cards to our front office, please read and sign this form as the guarantor.
Return completed form to the receptionist window.

I authorize direct payment of insurance to the providing dentist.

***Signature:** _____