

# WELCOME TO TALLGRASS ORAL SURGERY

For proper identification to assure that your experience here goes smoothly, please complete the following personal information to help us serve you.

Are you a new patient to our practice? No Yes

Has a member of your family been a patient in our office? No Yes Who? \_\_\_\_\_

## PATIENT INFORMATION:

Mr. Mrs. Ms. Miss Dr. Fr. Rev. Sister Nickname \_\_\_\_\_

\_\_\_\_\_  
First Mi Last Date of Birth Age

Social security # \_\_\_\_\_ Male / Female Marital status \_\_\_\_\_

\_\_\_\_\_  
Street address City State Zip code

Telephone: Home (\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_

Employer \_\_\_\_\_ Name of school if student \_\_\_\_\_ Full / Part Time

Patient living with: Mother Father Spouse Self Other \_\_\_\_\_  
Spouse's name/ If minor please list parents

\_\_\_\_\_  
Dentist Date of last visit Physician

Who referred you to our office? \_\_\_\_\_

## NAME OF FINANCIALLY RESPONSIBLE PARTY: \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone: Home (\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_

Date of birth \_\_\_\_\_ Male / Female Social security # \_\_\_\_\_

Marital Status: Single Married Divorced Separated Widowed Employer \_\_\_\_\_

## DENTAL INSURANCE: (MEDICAL & SECONDARY INSURANCE-REVERSE SIDE)

Insurance company name: \_\_\_\_\_

Insurance company address: \_\_\_\_\_

Employee name: \_\_\_\_\_ Insurance company telephone # \_\_\_\_\_

Insured employer: \_\_\_\_\_ Insured social security # \_\_\_\_\_

Insured date of birth: \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

(SEE REVERSE SIDE)

Updated: \_\_\_\_\_ Date: \_\_\_\_\_ Updated: \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICAL INSURANCE:**

Insurance company name \_\_\_\_\_

Insurance company address \_\_\_\_\_

Employee name \_\_\_\_\_ Insurance company telephone # \_\_\_\_\_

Insured employer \_\_\_\_\_ Insured social security # \_\_\_\_\_

Insured date of birth \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

**SECONDARY INSURANCE:**

Insurance company name \_\_\_\_\_

Insurance company address \_\_\_\_\_

Employee name \_\_\_\_\_ Insurance company telephone # \_\_\_\_\_

Insured employer \_\_\_\_\_ Insured social security # \_\_\_\_\_

Type: Dental Medical Both \_\_\_\_\_ Insured date of birth \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF INSURANCE BENEFITS, AND PAYMENT RESPONSIBILITY.**

The undersigned hereby authorizes Richard T. Darnall, DDS to furnish such information and records concerning the above-named patient's medical condition to other health care providers as may appear appropriate to the patient's care and treatment and also to furnish such information and records to the patient's immediate family. The undersigned hereby authorizes Richard T. Darnall, DDS to release any such information and records to any insurance company, benefit plan or governmental agency as may appear to be necessary to process any claim for dental /medical services provided to the patient and, hereby assigns Richard T. Darnall, DDS any right to receipt of payment for such services, such payment to be made directly to Richard T. Darnall, DDS. Except as otherwise prohibited **each person's signing below acknowledges full responsibility for the payment of all charges incurred by the above-named patient.** If the payment obligation is not met, the undersigned agrees to pay costs of collection, including (but not limited to) court costs and one-third contingency attorney's fees of the balance owed at the time of suit.

**A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.**

\_\_\_\_\_  
Patient/Responsible Person

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient/Responsible Person

\_\_\_\_\_  
Date