



# PATIENT INFORMATION

All Details Are Completely Confidential

[www.smilewv.com](http://www.smilewv.com)

## PATIENT

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_-\_\_\_\_-\_\_\_\_

License #/State: \_\_\_\_\_ / \_\_\_\_\_ Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Sex:  F  M Marital Status:  Single  Married  Separated  Divorced  Widowed

Employer/School: \_\_\_\_\_  Full Time  Part Time

Emergency Contact: \_\_\_\_\_ Relationship to Pt: \_\_\_\_\_ Phone: \_\_\_\_\_  
Must Be Different Than Above

**GUARDIAN** (if patient under 18)  N/A

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_-\_\_\_\_-\_\_\_\_

License #/State: \_\_\_\_\_ / \_\_\_\_\_ Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**INSURANCE** (if applicable)  N/A

### Primary Medical – \*Subscriber Only\*

Insurance Name: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Relationship to Pt: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_-\_\_\_\_-\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

\_\_\_\_\_

Employer Phone: \_\_\_\_\_

### Primary Dental – \*Subscriber Only\*

Insurance Name: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Relationship to Pt.: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_-\_\_\_\_-\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

\_\_\_\_\_

Employer Phone: \_\_\_\_\_

I, the Patient or Guardian named above, authorize the release of medical and financial information to Southern West Virginia Oral & Maxillofacial Surgeons, LTD as it relates to my consultation and/or treatment. I also authorize direct payment from my insurance to Southern West Virginia Oral & Maxillofacial Surgeons, LTD.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
DATE