Knox OMS
Knoxville Oral & Maxillofacial Surgery

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PERSONAL & FINANCIAL DATA

Patient Information

Patient Name (Please Print) First: MI: Last:	**Age**	**Date of Birth**
Street Address	**Home Phone**	
City **State** **Zip Code**	**Work Phone**	
Sex: M F Marital Status: M S W D **SS#**	**Cell Phone**	
Are you a student? ☐ Yes ☐ No ☐ Full-Time ☐ Part-Time	**Name/Address of School Attending**	
Employer Name, Address, Phone Number		
Who referred you to our office?	**Did you bring x-rays with you?**	
Personal Dentist	**Primary Care Physician / Name & Telephone Number**	
Why are you seeing the doctor today?		
Person Responsible for Account (if child, list attending parent information) First: MI: Last:	**Relationship to Patient**	
Street Address	**Mobile Phone**	
City **State** **Zip Code**	**Home Phone** **Work Phone**	
Employer	**SS#**	**Date of Birth**

Dental Insurance

Primary Dental Carrier _____ Group # _____
Insured's Name _____ ID# _____
Insured's Date of Birth _____ SS# _____ Employer _____
Secondary Dental Carrier _____ Group # _____
Insured's Name _____ ID# _____
Insured's Date of Birth _____ SS# _____ Employer _____

Medical Insurance

Primary Medical Carrier _____ Group # _____
Insured's Name _____ ID# _____
Insured's Date of Birth _____ SS# _____ Employer _____
Secondary Medical Carrier _____ Group # _____
Insured's Name _____ ID# _____
Insured's Date of Birth _____ SS# _____ Employer _____

Does your insurance require a referral? ☐ Yes ☐ No (It is the patient's responsibility to obtain a referral from their Primary Care Physician)
Managed Care Plan? ☐ Yes ☐ No **Point of Service Plan?** ☐ Yes ☐ No

I authorize Knoxville Oral Maxillofacial Surgery, PC, to furnish information to my insurance carriers concerning my illness and treatment, and hereby assign all payments for services rendered to myself or my dependent. I understand that I am responsible for any amount not covered by my insurance.

_____ _____
Signed Date