Woodinville Oral Surgery

PATIENT INFORMATION

NAME _____ _____
First Middle Initial Last Email

ADDRESS _____ CITY _____ STATE_____ ZIP _____

SEX ☐ M ☐ F AGE _____ BIRTHDATE _____ ☐ MARRIED ☐ SINGLE ☐ MINOR

EMPLOYER/SCHOOL _____ EMPLOYER/SCHOOL PHONE (_____) _____

GENERAL DENTIST _____ DENTIST PHONE (_____) _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

HAVE WE EXTRACTED ANY OTHER SIBLINGS' WISDOM TEETH? _____

EMERGENCY CONTACT _____ PHONE (_____) _____

BILLING INFORMATION

PERSON RESPONSIBLE FOR BILLING/PAYMENT _____
First Name Middle Initial Last Name

RELATIONSHIP TO PATIENT _____

ADDRESS (If Different from Patient's) _____ PHONE (_____) _____

CITY_____ STATE_____ ZIP _____

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE:

INSURANCE COMPANY NAME _____ SUBSCRIBER NAME _____

ADDRESS _____ SUBSCRIBER BIRTHDATE _____

CITY_____ STATE_____ ZIP _____ SUBSCRIBER ID# or SSN _____

INSURANCE PHONE #_____ GROUP # _____

RELATIONSHIP TO PATIENT _____

SECONDARY DENTAL OR MEDICAL INSURANCE:

INSURANCE COMPANY NAME _____ SUBSCRIBER NAME _____

ADDRESS _____ SUBSCRIBER BIRTHDATE _____

CITY_____ STATE_____ ZIP _____ SUBSCRIBER ID# or SSN _____

INSURANCE PHONE #_____ GROUP # _____

RELATIONSHIP TO PATIENT _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with the INSURANCE COMPANY LISTED ABOVE and assign directly to Dr. Ralph K. Zech all insurance benefits, if any, otherwise payable to me for services rendered **(I understand that I am financially responsible for all charges within 30 days from date of service)** unless arrangements have been made with our credit department. I authorize the use of my signature on all insurance submissions. The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please PRINT name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Patient's Home Phone (_____) _____ Cell Phone (_____) _____

Please see other side