Oral & Maxillofacial Surgery of Greater Grand Rapids, PLLC

To help meet all your healthcare needs, please fill out this form completely. If you have any questions or need assistance, Please ask and we will be happy to help.

All ESCORTS FOR IV SEDATION PATIENTS MUST REMAIN AT THE OFFICE

PATIENT INFORMATION (Confidential)

Name_______________________________Date of Birth_______________Male/Female
Address______________________________City_____________State_____Zip_______
Home Phone______________________Cell Phone_________________________________
Email Address for Confirmation____
SS#_____________________________Drivers Lic #_______________________________
Employer__________________________________Work Phone______________________
Emergency Contact Name & Phone #____
Dentist___________________________Referring Doctor___________________________
Name of High School or College _____________________Full Time/Part Time or NOT a Student

RESPONSIBLE PARTY (Parent or Legal Guardian with the minor, **NOT** Insurance Holder)
Name__________________________________Relationship to the patient _____________
Address______________________________City_____________State_____Zip________
Date of Birth______________SS#____________________Home Phone #_________________
Employer_____________________________________Work Phone #_________________
Email Address ____

Payment is required the day services are provided. For your convenience we accept the following:
PLEASE CIRCLE METHOD OF PAYMENT: Cash, Visa, Mastercard, AmEx, Discover, CareCredit

PRIMARY DENTAL INSURANCE
Insurance Co. __________________________________Group #____________________
Address_______________________________________Phone #____________________
Employer_____________________________________Work Phone #________________
Employee_________________________SS#__________________Date of Birth_____________
Address if different than patients____

SECONDARY DENTAL INSURANCE
Insurance Co.__________________________________Group #_____________________
Address______________________________________Phone #_____________________
Employer____________________________________Work Phone #_________________
Employee_________________________SS#__________________Date of Birth_____________
Address if different than patients____

PRIMARY MEDICAL INSURANCE
Insurance Co.__________________________________Group #_____________________
Address______________________________________Phone #_____________________
Employer____________________________________Work Phone #_________________
Employee_________________________SS#__________________Date of Birth_____________
Address if different than patients____

SECONDARY MEDICAL INSURANCE
Insurance Co.__________________________________Group #_____________________
Address______________________________________Phone #_____________________
Employer____________________________________Work Phone #_________________
Employee_________________________SS#__________________Date of Birth_____________
Address if different than patients____