GRANITE STATE ORAL SURGERY

PATIENT HEALTH HISTORY & REGISTRATION

Welcome to our office. Please provide us with the information requested below. All information is kept confidential.

Patient's Name: _____Today's Date: _____ **EMAIL:** _____

Male/Female: ___ Date of Birth: _____ Soc. Sec. #: _____ Home Phone: _____

Mailing Address: _____ State: _____Zip: _____

Residential Address: (if different): _____State: _____ Zip: _____

Employer/School: _____State: _____ Zip: _____ Phone: _____

Physician: _____Referring Dentist: _____

Preferred Pharmacy: _____Phone: _____

Responsible Party's Information: (Person Accompanying Patient if a minor or disabled)

Relationship to patient:_____Name:_____DOB:_____

Phone number _____ Soc. Sec. # _____

Address: _____State: _____ Zip: _____

Employer:_____ Address/Phone: _____

Email address: _____

Dental Insurance Plan: _____800 #: _____

Address: _____ Member ID # /Subscriber #: _____

Subscriber name: _____ DOB: _____ SS#: _____

Employer (name, address & telephone): _____

Medical Insurance Plan: _____800 #: _____

Address: _____Member ID # /Subscriber #: _____

Subscriber name:_____DOB: _____ SS#: _____

| | **I have read and been offered a copy of the HIPPA Privacy Policies of this office.**

Your signature is necessary for us to process any insurance claims and to ensure payment of services rendered.

I authorize release of all medical information necessary to process my insurance claims. I assign all medical and /or dental benefits to which I am entitled to Granite State Oral Surgery, PLLC. This assignment will remain effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I understand that I am financially responsible for the entire cost of my/my dependent's treatment charges. I understand that I am responsible for any collections and/or attorney's charges, should a collection procedure be necessary. I have read this information and understand it.

Patient/Legal Guardian: _____Date: _____