

Welcome to



NORTHSIDE
ORAL SURGERY

Board Certified Comprehensive Oral & Maxillofacial Surgery

DATE

Referred by: _____

Reason for Visit: _____

Has any family member been seen by Dr. Whitesides? _____ Whom? _____

Please complete the following confidential information:

PATIENT INFORMATION

Patient's Name: _____
First Middle

Last

Address: _____

City: _____ State: _____ Zip: _____

Phone Numbers

Home: _____ Work: _____

Cell: _____

email: _____

Patient's Date of Birth: _____ Sex: Male:
Female:

SS #: _____ (if over 18)

Employer: _____

Married Single Divorced

Student Partnered

PARENT/GUARANTOR INFORMATION

Parent/Guarantor: _____
Last First MI

Relationship to patient: _____

Address: _____

Home: _____ Work: _____

Date of Birth: _____ SS#: _____
of Guarantor of Guarantor

INSURANCE INFORMATION

Please check the payment method most convenient for you:
Check or Cash Visa/Mastercard

Medical Insurance

Policy Holder's Name: _____
Last First

Date of Birth: _____ SS#: _____
of insured of insured

Male: Female: Relationship to patient: _____

Insurance Co.: _____

Group #: _____

Dental Insurance

Policy Holder's Name: _____
Last First

Date of Birth: _____ SS#: _____
of insured of insured

Male: Female: Relationship to patient: _____

Insurance Co.: _____

Group #: _____

**IF YOU DO NOT HAVE INSURANCE CARD
PLEASE PROVIDE THE FOLLOWING:**

Policy Holder's Name: _____

Date of Birth: _____ SS#: _____

Phone # of Insurance Company: _____

ASSIGNMENT & RELEASE

I acknowledge and agree that payment for services rendered is due at the time that such service is performed and that payment or payment arrangements must be made in accordance with terms of the Financial Policy of Northside Oral Surgery (NSOS), which is expressly made a part of this agreement and I acknowledge receiving and reading a copy of the Financial Policy.

I authorized payment of benefits to NSOS for services rendered under the terms of my insurance policy, but not to exceed the balance due of my account and for NSOS to release any medical or other information necessary to process insurance claims. I further authorized photocopies of this form to be valid as the original. I authorize NSOS to leave messages on home/cell phone.

X _____ DATE _____

- | | | | |
|--|----|--|---|
| <input type="checkbox"/> <input type="checkbox"/> Ulcers | le | <input type="checkbox"/> <input type="checkbox"/> Glaucoma | <input type="checkbox"/> <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> <input type="checkbox"/> Cosmetic Surgery | | <input type="checkbox"/> <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> <input type="checkbox"/> Sickle Cell Disease |
| | | <input type="checkbox"/> <input type="checkbox"/> Heavy Snoring or Sleep Apnea | <input type="checkbox"/> <input type="checkbox"/> Bruise Easily |

- | | YES | NO |
|--|--------------------------|--------------------------|
| 8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you lost or gained more than 10 pounds in the past year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Are you currently taking any diet medication (Herbal, Over the Counter or Prescription)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Are you on a special diet? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Has your medical doctor ever said you have a cancer or tumor? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you smoke cigarettes, cigars or pipe tobacco products? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you use smokeless tobacco products (chewing tobacco, snuff)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you have any disease, condition, or problem not listed? | <input type="checkbox"/> | <input type="checkbox"/> |