SOUTHERN WEST VIRGINIA
ORAL & MAXILLOFACIAL SURGEONS, LTD

PATIENT INFORMATION

All Details Are Completely Confidential

www.smilewv.com

PATIENT

Name: _____ **DOB:** ____/____/_____ **SS#:** ____-____-_____

License #/State: _____/____ **Address:** _____

Home Phone: _____ **Alt. Phone:** _____ **Email:** _____

Sex: ☐ **F** ☐ **M** **Marital Status:** ☐ **Single** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**

Employer/School: _____ ☐ **Full Time** ☐ **Part Time**

Emergency Contact: _____ **Relationship to Pt:** _____ **Phone:** _____
Must Be Different Than Above

GUARDIAN *(if patient under 18)* ☐ N/A

Name: _____ **DOB:** ____/____/_____ **SS#:** ____-____-_____

License #/State: _____/____ **Address:** _____

Home Phone: _____ **Alt. Phone:** _____ **Email:** _____

INSURANCE *(if applicable)* ☐ N/A

Primary Medical – *Subscriber Only*

Insurance Name: _____

Subscriber Name: _____

Relationship to Pt: _____

DOB: ____/____/_____ **SS#:** ____-____-_____

Address: _____

_____

Employer Name: _____

Employer Address: _____

_____

Employer Phone: _____

Primary Dental – *Subscriber Only*

Insurance Name: _____

Subscriber Name: _____

Relationship to Pt.: _____

DOB: ____/____/_____ **SS#:** ____-____-_____

Address:

_____

Employer Name: _____

Employer Address: _____

_____

Employer Phone: _____

I, the Patient or Guardian named above, authorize the release of medical and financial information to Southern West Virginia Oral & Maxillofacial Surgeons, LTD as it relates to my consultation and/or treatment. I also authorize direct payment from my insurance to Southern West Virginia Oral & Maxillofacial Surgeons, LTD.

_____ _____ _____
SIGNATURE **PRINTED NAME** **DATE**

807 Broad Street
Summersville, WV 26651
P: (304) 872-0300
F: (304) 872-5999