



# Midlands Oral & Maxillofacial Surgery, P.A.

Please complete this form in full. Thank you.

James Lemon, D.M.D.  
Joseph W. Park, D.M.D.  
Heath M. Stewart, Jr., D.M.D.  
David B. Tevepaugh, D.M.D.

Referred By: \_\_\_\_\_ Reason For Visit: \_\_\_\_\_

Dentist Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Family Dr. / Phy.: \_\_\_\_\_ Phone: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Mr./Mrs./Miss: \_\_\_\_\_

(First) (Middle) (Last)

Address: (Street) (Apt #)

(City) (State) (Zip)

Telephone: (Home) (Business) (Other)

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  M  F Social Security #: \_\_\_\_\_

Marital Status:  M  S  D  W Driver's License #: \_\_\_\_\_

Employer: \_\_\_\_\_ School: \_\_\_\_\_

Responsible Party: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Address: (Street) (Apt #)

(City) (State) (Zip)

Telephone: (Home) (Business) (Other)

DOB: \_\_\_\_\_ SS #: \_\_\_\_\_ Employer: \_\_\_\_\_

Person to Contact in Case of Emergency:

(Other than above-named person) \_\_\_\_\_ Phone: \_\_\_\_\_

**INSURANCE INFORMATION: IT IS THE PATIENT'S RESPONSIBILITY TO OBTAIN PRIOR AUTHORIZATION OR PHYSICIAN REFERRAL IF NECESSARY.**

**Medical Insurance:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

Name of Policy Holder and Relationship \_\_\_\_\_ DOB: \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Phone # \_\_\_\_\_

**Dental Insurance:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

Name of Policy Holder and Relationship \_\_\_\_\_ DOB: \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Phone # \_\_\_\_\_

I authorize insurance benefits to be paid directly to Midlands Oral and Maxillofacial Surgery, P. A.

**Signature of Insured or Authorized Person:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**I understand and agree that I am ultimately responsible for payment.**

**BALANCE OF ACCOUNT BECOMES MY PERSONAL RESPONSIBILITY AFTER 45 DAYS OF FILING INSURANCE.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_