CRYSTAL COAST
ORAL & FACIAL SURGERY

Ryan T. Hagan DMD, PLLC

SECTION I: PATIENT INFORMATION

Name _____Nickname_____Male ☐ Female ☐

Address _____City_____ State_____ Zip_____

Home Phone# (____)_____ Cell Phone# (____)_____ Work Phone# (____)_____

Soc. Sec. No. _____ Date of Birth _____ Age _____ Employer _____

Marital Status _____ Spouse Name _____ Are you a full-time student? YES NO If so, where? _____

Emergency Contact Name: _____ Emergency Contact Phone #: _____

Who is responsible for your account? ☐ Self ***(If self, skip to Section III)*** ☐Spouse☐Father☐Mother☐Other ***(Please complete Section II)***

SECTION II: INSURED INFORMATION/PERSON FINANCIALLY RESPONSIBLE RELATION TO PATIENT _____

Name _____ Male ☐ Female ☐ Email _____

Address _____ City_____ State_____ Zip_____

Home Phone# (____)_____ Work Phone# (____)_____ Employer _____

Soc. Sec. No. _____ Date of Birth _____ Age _____ Occupation _____

Marial Status _____ Spouse Name _____ Occupation _____Work Phone# (____)_____

SECTION III: INSURANCE INFORMATION ***(Please provide photo ID and insurance card(s) for photocopying.)***

Primary Dental:
Insurance Carrier: _____
Claims Address: _____
_____
Phone# (____)_____
Patient ID # _____
Group # _____

Primary Medical
Insurance Carrier: _____
Claims Address: _____
_____
Phone# (____)_____
Patient ID # _____
Group # _____

Secondary Dental:
Insurance Carrier: _____
Claims Address: _____
_____
Phone# (____)_____
Patient ID# _____
Group # _____

Secondary Medical:
Insurance Carrier: _____
Claims Address: _____
_____
Phone# (____)_____
Patient ID# _____
Group # _____

Whom may we thank for referring you to our office? _____
Dentist's Name: _____ Physician Name/Phone# _____

Signing this page, you agree that all information above, is truthful and accruate and that you have been provided with a copy of this office's notice of "Privacy Practices". All charges are due and payable the day of services unless written preauthorization has been obtained. We will gladly provide and submit insurance forms for you as a curtosy. Regardless of the patient's estimated insurance benefits, the patient or guarantor is ulitmately responsible for all charges incurred in this office. Signing this page authorizes the following signatures to be kept as "signature on file" and used for insurance and payment purposes.

_____ _____ _____
Patient Signature Date **Guarantor Signature** Date **Relationship to Patient**