Palmetto Oral and Maxillofacial Surgeons, P.A.

Dr. F. Douglas Oliver
Dr. J. Michael Morgan, IV
Dr. Matthew T. Lee

Date _____ ( ) OLIVER ( ) MORGAN ( ) LEE

Chart # _____ Referring Physician / Dentist _____

Have you been a patient in this office before? _____ Yes _____ No If so, when? _____

PATIENT INFORMATION

Name _____
First Middle Last

Home Address _____ City/Zip _____

Home Ph. # _____ Work Ph. # _____ Cell Ph. # _____

Date of Birth _____ Sex: ___ Male ___ Female Marital Status: ___ Single ___ Married

Social Security # _____ Age _____

Patient Employed By _____ Occupation _____

Notify in case of emergency _____ Home/Work Ph. _____

PARENT OR GUARDIAN SIGNING PAYMENT AGREEMENT

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell: _____

Birth Date: _____ Social Sec: _____ Drivers Lic: _____

Primary Insurance

Medical _____

Dental _____

Policy Holder's Name _____

Policy Holder's Employer _____

Relationship to Patient _____

Birth Date _____ SSN _____

Address (if different from above) _____

City/State/Zip _____

Secondary Insurance

Medical _____

Dental _____

Secondary Policy Holder's Name _____

Secondary Policy Holder's Employer _____

Relationship to Patient _____

Birth Date _____ SSN _____

Address (if different from above) _____

City/State/Zip _____

Medicare _____ Medicaid _____

I GIVE PALMETTO ORAL & MAXILLOFACIAL SURGEONS, P.A. PERMISSION TO RELEASE ANY INFORMATION RELATING TO MY CLAIM AND I ALSO ASSIGN INSURANCE PAYABLE TO THIS OFFICE.

SIGNATURE OF PATIENT OR PARENT _____

REQUEST FOR RELEASE OF MEDICAL RECORDS

TO: _____

(PHYSICIAN)

_____

(ADDRESS)

_____

(CITY) (STATE) (ZIP CODE)

I hereby request that my medical records be released to:

_____

(PHYSICIAN)

_____

(ADDRESS)

_____

(CITY) (STATE) (ZIP CODE)

_____

(DATE)

_____

(PATIENT'S SIGNATURE)