Wilmington Oral Surgery
compassionate excellence

Scott A. Puckett, D.D.S.

Date _____

PATIENT INFORMATION Driver's License # _____State _____

First Name _____MI _____Last Name _____Nickname _____

Sex ( ) Female ( ) Male Date of Birth _____ Age _____ SS# _____

Student: Full Time ( ) Part Time ( ) School Name _____ ___City/State_____

Home Address _____ _____
(Street Number, City, State, Zip Code)

Phone (Home) _____ (Cell) _____ (Other) _____

Employer _____Business Phone _____Ext _____

Dentist _____Medical Doctor _____Referred by_____

PARENT/GUARDIAN INFORMATION Driver's License #_____State _____

First Name _____MI _____Last Name _____

Mother ( ) Father ( ) Guardian ( ) Other ( ) _____

Address _____
(Street Number, City, State, Zip Code)

Phone (Home)_____ (Cell) _____(Other) _____

Employer _____Business Phone _____Ext _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT? : Self ( ) Spouse ( ) Parent ( ) Step-parent ( ) Guardian ( )

Married ( ) Divorced ( ) Widow ( ) Single ( )

The information provided above to Wilmington Oral Surgery is correct to the best of your knowledge.

_____ _____
Signature (patient, parent or guardian) **Date**

Continue to complete the insurance section on next page. Please have all of your medical and dental cards present.

Continued . . . WILMINGTON ORAL SURGERY

Patient Name: _____DOB: _____

Primary Dental Insurance Company: _____

Address: _____

_____Phone #: _____

Employer: _____ID#_____ Group #_____

Employee: _____Relationship_____ SS#____-___-_____ DOB: _____

Secondary Dental Insurance Company: _____

Address: _____

_____Phone #: _____

Employer: _____ID# _____Group #_____

Employee: _____Relationship_____SS#____-___-_____ DOB: _____

Primary Medical Insurance Company: _____

Address: _____

_____Phone #: _____

Employer: _____ID#_____ Group#_____

Employee: _____Relationship_____SS#____-___-_____ DOB: _____

Secondary Medical Insurance Company: _____

Address: _____

_____Phone #: _____

Employer: _____ID# _____Group # _____

Employee: _____Relationship_____SS#____-___-_____DOB: _____

Insurance is filed as a courtesy by our office. The account is your responsibility and the co-pay or any balance is payable at the time service is rendered. A binding arrangement for payment is necessary at the first appointment. Please indicate your method of payment below:

( ) CASH ( ) CHECK ( ) CREDIT CARD ( ) PAYMENT PLAN (requires approval)

The information provided above to Wilmington Oral Surgery is correct to the best of your knowledge. SIGN _____DATE_____