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) ________________________ (Email) _________________________

Employer _______________________________________Business Phone _______________________Ext ___________

Dentist _______________________Medical Doctor _______________________Referred by______________________

PARENT/GUARDIAN INFORMATION Driver's License #_______________State ____________

First Name _______________________________MI ______Last Name _______________________________________

DOB _____________ Mother ( ) Father ( ) Guardian ( ) Other ( ) ____

Address ____

(Street Number, City, State, Zip Code)

Phone (Home)_________________________ (Cell) _________________________ (Email) ________________________

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: ____

Insurance Address: ____

____Phone #: ____________________

Employer: ____ID#____________ Group #______________

Employee: ____________________Relationship__________ SS#____-___-_____ DOB: ______________

Secondary Dental Insurance Company: ____

Insurance Address: ____

____Phone #: ____________________

Employer: ____ID# ____________Group #______________

Employee: ____________________Relationship___________SS#____-___-_____ DOB: ______________

Primary Medical Insurance Company: ____

Insurance Address: ____

____Phone #: ___________________

Employer: ____ID#____________ Group#______________

Employee: ____________________Relationship__________SS#____-___-______ DOB: ______________

Secondary Medical Insurance Company: ____

Insurance 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__________