Champlain Valley Oral & Maxillofacial Surgery Associates
Welcome to our Practice

Today's Date:_____

Patient Information:

Patient First Name:_____ MI:_____ Last Name: _____

Sex: ___Male ___Female Date of Birth: ____/____/____ Age:_____ Soc.Sec.#_____/_____/_____

Street Address:_____ Apt. or Box #_____
(if a PO box, please include street name)

City:_____ State: _____ Zip Code:_____

Home Phone #: (___)_____

Marital Status: Single___ Married___ Separated___ Divorced___ Widowed___ Civil Union___ Domestic Partner____

Student: Yes____ No____ If yes, Full Time _____ Part Time _____

School Name: _____ City:_____ State:____

Patient's
Employer:_____ Work Phone Number:_____

General Dentist: _____ Primary Care Physician: _____

Referred to our practice by: _____

Emergency Contact:_____ Day Phone#: _____
(Relationship to Patient)

Person Responsible for Account Balance: ❑ **Same as Patient**

First Name: _____ MI _____ Last Name:_____

Date of Birth: _____/_____/_____ Social Security #: _____/_____/_____

Address: _____
Street City State Zip Code

Home Phone (___)_____ Work Phone (____)_____

Marital Status: Single___ Married___ Separated___ Divorced___ Widowed___ Civil Union___ Domestic Partner____

Employer:_____

Medical and Dental Insurance Information

NOTE: If you are divorced and the insurance benefits and responsibility for out-of-pocket expenses are defined in your divorce decree, please advise us so we may process your account correctly. Thank you!

Primary Medical Insurance:

Insurance Plan Name: _____

Insurance Plan Address:_____

_____
City State Zip Code

Phone#:(____)_____Group#:_____

Employer:_____

Policy Holder:_____

Patient's Relationship to Policy Holder:
Self___Spouse___Child___ Stepchild___Other___

Policy Holder's SS#_____/_____/_____

ID#:_____

Policy Holder's Date of Birth: ____/____/____

Primary Dental Insurance:

Insurance Plan Name:_____

Insurance Plan Address:_____

_____
City State Zip Code

Phone#:(____)_____Group#:_____

Employer:_____

Policy Holder:_____

Patient's Relationship to Policy Holder:
Self___Spouse___Child___ Stepchild___Other___

Policy Holder's SS#_____/_____/_____

ID#:_____

Policy Holder's Date of Birth: ____/____/____

Secondary Medical Insurance:

Insurance Plan Name: _____

Insurance Plan Address:_____

_____
City State Zip Code

Phone#:(____)_____Group#:_____

Employer:_____

Policy Holder:_____

Patient's Relationship to Policy Holder:
Self___Spouse___Child___ Stepchild___Other___

Policy Holder's SS#_____/_____/_____

ID#:_____

Policy Holder's Date of Birth: ____/____/____

Secondary Dental Insurance:

Insurance Plan Name:_____

Insurance Plan Address:_____

_____
City State Zip Code

Phone#:(____)_____Group#:_____

Employer:_____

Policy Holder:_____

Patient's Relationship to Policy Holder:
Self___Spouse___Child___ Stepchild___Other___

Policy Holder's SS#_____/_____/_____

ID#:_____

Policy Holder's Date of Birth: ____/____/____