REYNALDO T. REESE, DMD – Oral and Maxillofacial Surgery

Today's Date_____ **PATIENT INFORMATION:**

Last Name:_____ First_____ MI_____ Preferred Name_____

Address:_____**APT#**_____City:_____ State:_____ Zip:_____

Home Ph# (_____)_____ Cell Ph# ***(skip if patient is under 18)*** (_____)_____

Birth Date_____/_____/_____ Age:_____ Social Security #:_____ E-Mail:_____

Dentist:_____ Medical Physician:_____ Referring Dr:_____

Emergency Contact Name_____ Relation_____Ph#(_____)_____

**Complete the following if patient is over 18:*

*Employer:_____ Number of years employed:_____ Work# (_____)_____

FINANCIAL RESPONSIBILITY: (MUST be completed by the responsible party.)

**If the patient above is responsible, skip to next section.*

Last Name:_____ First_____MI____ Birth Date_____/_____/_____ SS#_____

Address:_____Apt#_____City:_____ State:_____ Zip:_____

Home Ph#(_____)_____ Cell#(_____)_____ Work Ph#(_____)_____

Relationship to patient: (Father)(Mother)(Spouse)(other_____)

Signature of Responsible Party:_____ **Date:**_____

Primary Dental Ins Co Name_____

ID #_____ Group #_____

Ph#_____

Policy Holder Name:_____

Birth Date:_____/_____/_____ SS#_____

Relation:_____Employer:_____

Primary Medical Ins Co Name_____

ID #_____ Group #_____

Ph#_____

Policy Holder Name:_____

Birth Date:_____/_____/_____ SS#_____

Relation:_____Employer:_____

Secondary Dental Ins Co Name_____

ID #_____ Group #_____

Ph#_____

Policy Holder Name:_____

Birth Date:_____/_____/_____ SS#_____

Relation:_____Employer:_____

Secondary Medical Ins Co Name_____

ID #_____ Group #_____

Ph#_____

Policy Holder Name:_____

Birth Date:_____/_____/_____ SS#_____

Relation:_____Employer:_____