JOHN D. ROAN, D.D.S.
Diplomate - American Board of Oral & Maxillofacial Sugery
Valdosta Oral & Maxillofacial Surgeons, P.C.

PATIENT INFORMATION

(Please print and sign at the bottom)

Account # _____

Mr. Mrs. Ms. Miss Dr. _____
First MI Last Nickname

Address: _____ City/State: _____ Zip: _____

Home Tel Number: _____ Work Tel Number: _____

Date of Birth _____/_____/_____ Age _____ Sex: ❑ Male ❑ Female Cell Phone _____

Soc. Sec. #: _____ Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Employer: _____ Occupation: _____

Name of your Dentist: _____ Physician: _____ Orthodontist: _____

Who referred you to our office? ❑ Dentist ❑ Physician ❑ Orthodontist ❑ Friend _____ ❑ Other _____

Have you or any member of your family been a patient in our offices before? ❑ Yes ❑ No ❑ When (Year)? _____

Who: _____ Relationship: _____

If patient is a full-time student, name of school: _____

Emergency contact: _____ Daytime Tel Number: _____

Relationship to patient: _____

PERSON RESPONSIBLE FOR ACCOUNT

Is someone other than the patient responsible for this account? ❑ Yes ❑ No *If yes, please complete the following information:*

Name: _____ DOB _____/_____/_____ SSN#: _____ Home Phone: _____

Address: _____ City/State: _____ Zip: _____

Relationship to patient: _____ Occupation: _____ Work Phone: _____

INSURANCE COVERAGE INFORMATION

DENTAL

❑ Copy of card

Primary Dental Insurance

Name of insurance company: _____

Insured Name: _____ DOB _____/_____/_____ Insured Daytime Phone: _____

Insured Soc. Sec. #: _____ Plan ID (if other than SS#): _____

Relationship to patient: _____ Group #: _____ Employer Name: _____

Insurance Co. Address: _____ Insurance Co. Phone: _____

_____

INSURANCE COVERAGE INFORMATION

MEDICAL

If there is additional coverage, please use other side of form.

❑ Copy of card

Primary Medical Insurance

Name of insurance company: _____

Insured Name: _____ DOB _____/_____/_____ Insured Daytime Phone: _____

Insured Soc. Sec. #: _____ Plan ID (if other than SS#): _____

Relationship to patient: _____ Group #: _____ Employer Name: _____

Insurance Co. Address: _____ Insurance Co. Phone: _____

_____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I understand in signing this statement that I am financially responsible to Valdosta Oral and Maxillofacial Surgeons, P.C. for all fees incurred and all costs of collection: including, but not limited to, if necessary, service, collection, collection agency, and attorney charges. I hereby authorize the insured's insurance company to pay directly to Dr. John D. Roan any and all of the benefits otherwise payable to me. I further authorize the release of health care information for the purpose of evaluating and administering claims for benefits.

Signed: _____ **Date:** _____

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