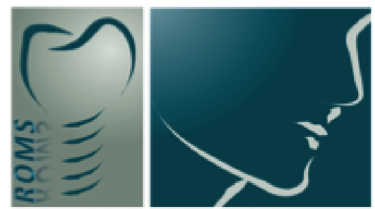
Richmond Oral and Maxillofacial Surgery, LLC
1004 Oak Drive
Richmond, IN 47374
(765) 935-1997



PATIENT INFORMATION (Please Print)

Patient Name: ______________________________ **Sex:** M F **Marital Status:** Ch S M D W **Birth Date:** ____________ **SS#:** ______________ **Age:** _____

Patient Address: ____ **City:** ________________________ **State:** ________ **Zip:** ____________________

Home Phone: (_______)______________________ **Cell Phone:** (_______)______________________ **Work Phone:** (_______)________________________

Employer: ____ **Position:** ____

Employer Address: ____ **City:** ________________________ **State:** ________ **Zip:** ____________________

Referred By: _____________________________ **What is the purpose of seeing the doctor today?** ____

RESPONSIBLE PARTY INFORMATION

Responsible Party: ☐ Patient ☐ Father ☐ Mother ☐ Husband ☐ Wife **Name:** _______________________________ **Birth Date:** ___________ **SS#:** _______________

Address: ____ **City:** ___________________________ **State:** __________ **Zip:** _____________________

Home Phone: (_______)______________________ **Cell Phone:** (_______)______________________ **Work Phone:** (_______)________________________

Employer: ______________________________ **Position:** _______________________ **Employer Address:** ____

Spouse's or Parent's Name (other than responsible party): ____ **Birth Date:** _____________ **SS#:** _______________

Address: ____ **City:** ___________________________ **State:** __________ **Zip:** _____________________

Home Phone: (_______)______________________ **Cell Phone:** (_______)______________________ **Work Phone:** (_______)________________________

Employer: ______________________________ **Position:** _______________________ **Employer Address:** ____

Name of Relative (other than living with you): ___________________________________ **Relationship:** _________________ **Phone:** (______)___________________

Address: ____ **City:** ___________________________ **State:** __________ **Zip:** _____________________

Name of Friend: ____ **Phone:** (______)___________________

Address: ____ **City:** ___________________________ **State:** __________ **Zip:** _____________________

INSURANCE COMPANY INFORMATION (Primary)

Name of Company: ____ **Phone:** (_______)________________________

Address: ____ **City:** ___________________________ **State:** __________ **Zip:** _____________________

Does your plan cover: ☐ Dental ☐ Medical ☐ Both **Group #:** ____________________________ **Employer:** ____

Name of Insured (person who carries insurance): ____ **Relation of Patient to Insured:** ☐ Self ☐ Spouse ☐ Child ☐ Other

Sex of Insured: M F **Insured's Birth Date:** __________________ **Phone:** (______)_________________ **SS#:** _________________ ***or* ID#:** ___________________

Address: ____ **City:** ___________________________ **State:** __________ **Zip:** _____________________

INSURANCE COMPANY INFORMATION (Secondary)

Name of Company: ____ **Phone:** (_______)________________________

Address: ____ **City:** ___________________________ **State:** __________ **Zip:** _____________________

Does your plan cover: ☐ Dental ☐ Medical ☐ Both **Group #:** ____________________________ **Employer:** ____

Name of Insured (person who carries insurance): ____ **Relation of Patient to Insured:** ☐ Self ☐ Spouse ☐ Child ☐ Other

Sex of Insured: M F **Insured's Birth Date:** __________________ **Phone:** (______)_________________ **SS#:** _________________ ***or* ID#:** ___________________

Address: ____ **City:** ___________________________ **State:** __________ **Zip:** _____________________

Today's Date: _______________________