CLARK & GOSSETT
IMPLANT AND ORAL SURGERY
Diplomates, American Board of Oral and Maxillofacial Surgery

Charles L. Clark, DDS
James D. Gossett, DDS
Steven E. Cross, DDS

## Patient Information:

**Today's Date:** _____/_____/_____

First Name: _____ MI: _____ Last Name: _____

Sex: Male Female Birthdate: _____/_____/_____ Age: _____

Social Security #: _____ E-Mail: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Driver's License #: _____ Driver's License State: _____

Employer Name: _____ Phone Number: _____

Have you ever had an appointment or been a patient of our practice? Yes No

## Referral Information:

How did you hear about us (referral source): Facebook Google/Search Engine Family/Friend

Insurance Company: _____ Referring Doctor: _____

## Emergency Contact Information:

Emergency Contact Name: _____

Relationship: _____ Emergency Contact Phone #: _____

## Responsible Party Information (If Different from Patient/Patient is a Minor):

First Name: _____ MI: _____ Last Name: _____

Relationship to Patient: Self Spouse Parent Other: _____

Sex: Male Female Birthdate: _____/_____/_____ Age: _____

Social Security #: _____ E-Mail: _____

Employer of Insured: _____ Phone #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

## Secondary Insurance Information:

Do you have a secondary Dental insurance? Yes No Insurance Company:_____