Brandon C. Payne, DDS, MD
Oral & Maxillofacial Surgeon

Southern Colorado
Oral & Facial Surgery

PATIENT INFORMATION

Patient: First Name___________________ M.I.____ Last Name___________________________Preferred name:_________________________

Sex: [ ] Male [ ] Female Birth Date_________________ Age_______ Social Sec. # ________________________ Email_______________________________

Street____ City_______________________ State_________ Zip Code __________________

Home Phone(______)_______________ Work Phone(______)_________________ Cell Phone(_______)_______________

Dentist____ Physician ____

Driver's License #____________________ **Emergency Contact**______________________ Phone__________________ Relation _______________________________

Who referred you to this office? ________________________ Have you ever been a patient in our office? [ ] Yes [ ] No When?_______________________

Did we ever treat you under a different name? [ ] Yes [ ] No If yes, list prior name ____

What is your preferred contact phone? Wireless Home Work

RESPONSIBLE PARTY INFORMATION

Who will be responsible for paying any amount not covered by insurance? [ ] Self [ ] Spouse [ ] Father [ ] Mother [ ] Other ______________________

Name_______________________________________ Soc Sec # _________________________ Home Phone(______)________________ Cell Phone(_______)______________

Birth Date_____/_______/_____ Employer Name___________________________ City_________________ State_____ Zip___________ Work Phone (_____)_______________

Street______________________________________ City________________________ State______ Zip Code _________________

Name of Spouse or Parents___________________________ Soc Sec # _____________________ Home Phone(______)_______________

Street______________________________________ City________________________ State______ Zip Code ________________

Employer Name___________________________City_________________________State________Zip___________ Work Phone(______)_______________

INSURANCE INFORMATION

Patient: Student: [ ] Full Time [ ] Part Time [ ] Not School Name/Address ____

Married: [ ] Married [ ] Divorced [ ] Child [ ] Widow [ ] Single

Employed: [ ] Full Time [ ] Part Time [ ] Retired [ ] Not Do you belong to a PPO or HMO?____________

PRIMARY DENTAL INSURANCE

Relationship to subscriber Self Spouse Child

Employer ____

Bus. Tel #_______________________ Plan ______________________

Ins. Co. Name____

Street____

City/St/Zip _____________________Phone______________________

Group #_____________________**Group Name**___________________

Policy Holder____

Date of Birth ________________ SS# ____________________________

Street____

City/St/Zip _____________________Phone______________________

ID Number___________________________________

PRIMARY MEDICAL INSURANCE

Relationship to subscriber Self Spouse Child

Employer ____

Bus. Tel #___________________________ Plan ________________________

Ins. Co. Name____

Street____

City/St/Zip _____________________Phone______________________________

Group #_______________**Group Name**_______________________________

Policy Holder____

Date of Birth _______________________ SS# __________________________

Street____

City/St/Zip __________________________Phone_________________________

ID Number____

SECONDARY DENTAL / MEDICAL INSURANCE

Relationship to subscriber Self Spouse Child

Employer ____

Bus. Tel #_______________________ Plan ______________________

Ins. Co. Name____

Street____

City/St/Zip _____________________Phone______________________

Group #_____________________**Group Name**___________________

Policy Holder____

Date of Birth ________________ SS# ____________________________

Street____

City/St/Zip _____________________Phone______________________

ID Number___________________________________

COMPLETE IF YOU HAVE MEDICAID

What State?____

Name as it Appears on Card ____

Medicaid State ID Number____________________________________