Texas Institute of Oral, Facial & Implant Surgery
1741 N. Hwy 67, Midlothian, Texas 76065
(469) 649-8259 office - (469) 649-8256 fax
info@txinstituteoms.com

Responsible Party (if other than patient)

Parent/Spouse Name_____ Age_____
Birthdate_____ Social Security # _____ Driver License # _____
Address_____ City_____ State_____ Zip Code_____ Apt#_____
Home Phone_____ Cell Phone_____ Email _____
Employer_____ Business Phone_____ Ext. _____

Primary Dental Insurance Information

Policy Holder _____ Birthdate _____ Social Security # _____
Patient Relationship to Insured: ___◯___Self ___◯___Spouse ___◯___Child _____Other
Insurance Company _____ Employer_____
Member ID # _____ Group # _____ Phone # _____

Primary Medical Insurance Information

Policy Holder _____ Birthdate _____ Social Security # _____
Patient Relationship to Insured: ___◯___Self ___◯___Spouse ___◯___Child _____Other
Insurance Company _____ Employer_____
Member ID # _____ Group # _____ Phone # _____

FINANCIAL ARRANGEMENTS

All fees are due at the time services are rendered.

Cash___◯___ **Check**___◯___ **Charge**___◯___ **Insurance** (name of carrier) _____

I hereby certify that I have answered the above questions correctly and will not hold my doctor, or any other member of his staff responsible for any errors or omissions that I have made in the completion of this form.

Patient Signature (parent/guardian if patient is a minor)_____