DEAN C. YOUNCE, D.M.D., P.A.
Oral & Maxillofacial Surgery

PATIENT INFORMATION

NAME ____ I prefer to be called ____________________
☐ Male ☐ Female Birth date _____________ Age ______ Social Security No. __________________
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor (Child)

HOME ADDRESS ____
City ____ State ________________ Zip ____________
Home Phone ___________________ Work Phone ___________________ Pager/Cell No.____________
When and where are the best times to reach you? ____
Who referred you to our office? _____________________________ School Name__________________

EMPLOYER ________________________________ How Long There? _______ Title _______________
Employer's Address ____ Phone __________________

PERSON RESPONSIBLE FOR ACCOUNT

NAME _________________________________ Relationship ___________ Home Phone ______________
Billing Address: ____ Pager/Cell No. ______________
City: ____ State: _________ Zip ____________
Social Security No._________________ Birthdate _____________ Drivers Lic No._________________

EMPLOYER____ Work Phone ________________
Employer's Address____
City____ State ___________ Zip____________

SPOUSE INFORMATION

His/Her Name____ Birthdate_____________
Social Security No.___________________ Employer____

INSURANCE INFORMATION

PRIMARY INSURANCE Medical coverage? ☐ Yes ☐ No Dental Coverage? ☐ Yes ☐ No
Ins. Co. Name____ Phone No___________________
Ins. Co. Address_________________________________ City______________ State______ Zip_______
Insured's Name_______________________________________ Social Security No____________________
Insured's Birthdate__________________ Relationship___________________ Group No_______________

SECONDARY INSURANCE Medical coverage? ☐ Yes ☐ No Dental Coverage? ☐ Yes ☐ No
Ins. Co. Name____ Phone No___________________
Ins. Co. Address_________________________________ City______________ State______ Zip_______
Insured's Name_______________________________________ Social Security No____________________
Insured's Birthdate__________________ Relationship__________________ Group No________________