ORAL & MAXILLOFACIAL SURGERY
Hennig, Woodbury & Howard PC

PATIENT INFORMATION SHEET **NICKNAME: _____**

☐Mr. ☐Mrs. ☐Ms. ☐Dr. First Name _____ M.I. ____ Last Name _____

Address _____ City_____ State _____ Zip_____

Date of Birth _____ / Age _____ Soc. Sec. #_____ Driver's Lic# _____

Home Phone _____ Cell Phone _____ Work Phone_____

Status: ☐Married ☐Divorced ☐Separated ☐Widow ☐Single Employed: ☐☐Full Time ☐Part Time ☐Retired

Employer: _____ Emp. Address_____

Has a family member ever been a patient of our office? ☐Yes ☐No Name of family member_____

General Dentist: _____ Orthodontist: _____

Medical Doctor: _____

I authorize my surgeon and his designated staff to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays and photographs required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment. By signing this, I understand that I am responsible for the charges for the above named patient.
We accept cash, personal, checks, cashiers checks, money orders, all major credit cards and Care Credit. There will be a $25.00 fee for all non-sufficient funds checks returned to us.

Signature _____ Date _____

HIPAA
Health Insurance Portability and Accountability Act of 1996
I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.
I also understand that my account or treatment will not be discussed with anyone other than myself unless their name is listed below. This includes any spouses or your parents if you are over 18. Even if your parent holds the insurance we may not discuss your account with them unless they are listed below.

I authorize you to speak with: _____

Signature _____ Date _____

IF PATIENT IS UNDER 18

PERSON HERE WITH PATIENT: ☐Mother ☐Father ☐Step Parent ☐Grandparent ☐Guardian ☐Other

NAME OF PARENT/GUARDIAN HERE WITH PATIENT

☐Mr. ☐Mrs. ☐Ms. ☐Dr. First Name _____ M.I. ____ Last Name _____

Address _____ City_____ State _____ Zip_____

Date of Birth _____ / Age _____ Soc. Sec. #_____ Driver's Lic# _____

Home Phone _____ Cell Phone _____ Work Phone_____

Status: ☐Married ☐Divorced ☐Separated ☐Widow ☐Single Employed: ☐☐Full Time ☐Part Time ☐Retired

Employer: _____ Emp. Address_____