ADVANCED ORAL SURGERY OF THE FINGER LAKES
Pasquale Scutari, Jr., D.D.S.

Patient Name: ______________________________________Gender: M F Date of Birth: _____/_____/_____

Primary Phone (____)______________ Other (____)_____________ Work Phone (____)____________

Who Referred You to Our Office?________________________________ Social Security #: ________________

Home Address: _______________________________ City, State, Zip: _________________________________

Employer Name: _____________________________________ Employer Phone (____)___________________

Significant Other or Parents / Guardians (if under 18):

Name: __________________________________ Relationship: _______________ Phone (___)_____________

Address: ________________________________ Employer Name: _____________________________________

Name: __________________________________ Relationship: _______________ Phone (___)_____________

Address: ________________________________ Employer Name: _____________________________________

In Case of Emergency Notify:

Name: __________________________________ Relationship: _______________ Phone (___)_____________

INSURANCE INFORMATION: *If you have insurance coverage, please fill out the following section. We will ask to make copies of your insurance cards.*

PRIMARY DENTAL

Company ____________________________

Claims Address ____________________________

Insured Name ____________________________

ID # / Group # ____________________________

SECONDARY DENTAL

Company ____________________________

Claims Address ____________________________

Insured Name ____________________________

ID #/ Group # ____________________________

PRIMARY MEDICAL

Company ____________________________

Claims Address ____________________________

Insured Name ____________________________

ID # / Group # ____________________________

SECONDARY MEDICAL

Company ____________________________

Claims Address ____________________________

Insured Name ____________________________

ID #/ Group # ____________________________

RELEASES: Should your carrier request information to process a claim, or we file a claim for you, we need for you to read & sign the following two releases:

1. Authorization to Assign Payments to Advanced Oral Surgery of the Finger Lakes

I authorize payment of my dental/medical insurance benefits directly to Advanced Oral Surgery of the Finger Lakes for services rendered. I understand that I am financially responsible for services rendered. A copy of this authorization shall be as valid as the original.

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Signature ***Date***

2. Authorization to Release Information to Insurance Company

I authorize Advanced Oral Surgery of the Finger Lakes to release any information acquired in the course of my examination or treatment relating to processing of my insurance claims.

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Signature ***Date***