Southern Nevada Oral & Maxillofacial Surgery
Jay K. Selznick, D.M.D., M.D.

Patient Information

Name: _____ D.O.B.:_____ Sex: __M / F / Prefer not to answer__

Marital Status: _Married/Single/Divorced/Widowed_ Home Phone: _____ Cell: _____

Address: _____
(Street) (City) (State) (Zip)

SSN:_____ Employer:_____ Occupation: _____

Responsible party name (if patient is a minor):_____ D.O.B.:_____

Address (if different than above): _____
(Street) (City) (State) (Zip)

Relationship to patient:_____ Cell:_____ Home:_____ Work: _____

Pharmacy Name and address:_____

Who may we thank for referring you to our office/how did you hear about us? _____

Primary Dental Insurance

Insurance company Name:_____ Phone #:_____

Ins co. address: _____
(Street) (City) (State) (Zip)

Policy Holder's Name:_____
(Last) (First)

D.O.B.:_____ Member ID/SSN:_____ Group#_____

Policy holder address (if different from patient):_____
(Street) (City) (State) (Zip)

Employer:_____ Occupation:_____

Relationship to patient:_____

Secondary Dental Insurance

Insurance company Name:_____ Phone #:_____

Ins co. address: _____
(Street) (City) (State) (Zip)

Policy Holder's Name:_____
(Last) (First)

D.O.B.:_____ Member ID/SSN:_____ Group#_____

Policy holder address (if different from patient):_____
(Street) (City) (State) (Zip)

Employer:_____ Occupation:_____

Relationship to patient:_____

I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and certify that this information is true and correct to the best of my knowledge. I will notify the office of any changes in my status or the above information.

Signature of patient/legal guardian: _____ Date: _____