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

Patient Name: _____Gender: M F Date of Birth: _____/_____/_____
Home Phone (____)_____ Mobile Phone (____)_____ 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.

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.

Signature ***Date***