Northwest Florida Oral & Maxillofacial Surgery

4850 North Ninth Avenue
Pensacola, FL 32503
850-478-7070 / FAX 850-476-2513

J. Larry Morris, DMD

Brett T. Laggan, DDS

Patient's Last Name: ______________________________ First Name: _______________________________ Middle Initial: _____

SSN: ______________________ Date of Birth: _____________ Age: ___________ Sex: ☐Male ☐Female

Address: ____ City: ______________ State: _____ Zip: ________

Home Phone: __________________________ Work Phone: ________________________ Cell Phone: ______________________

E-mail Address:____ May we contact you via email? ☐Yes ☐No

☐Single ☐Married ☐Widowed ☐Separated/ Divorced ☐Student Student Status: ☐ PT ☐FT

Employer: _________________________________ Employer Address: ____

What is or was your occupation? ____ ☐ Retired?

Name and contact # of Spouse/Parent/Legal Guardian: ____

Referring Dentist Name, Address, & Phone #:____

Primary Doctor's Name, Address, & Phone #:____

Pharmacy Name & Phone #:____

Emergency Contact: ___________________________________ Phone #: ____

Dental Insurance

Insurance Company:___________________________________ Policy #_____________________ Group # __________________

Ins. Co. Address: ____ Ins. Co. Phone Number:___________________________

Policy Holder Name: _____________________________ Policy Holder SSN: _________________ Policy Holder DOB: __________

Patient's Relationship to Insured: ____

Secondary Insurance Company: ____

Medical Insurance

Insurance Company:___________________________________ Policy #_____________________ Group # __________________

Ins. Co. Address: ____ Ins. Co. Phone Number: ___________________________

Policy Holder Name: _____________________________ Policy Holder SSN: _________________ Policy Holder DOB: __________

Patient's Relationship to Insured:____

I WILL BE PAYING BY: ☐CASH ☐CHECK ☐CREDIT CARD

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full.

Responsible Party Signature: ____ ***Date:*** ______________