*LAKE CHARLES ORAL & FACIAL SURGERY*

**G. Rawleigh Fisher, DDS, MD**

Diplomate, American Board of Oral & Maxillofacial Surgery

**WELCOME TO OUR PRACTICE**

## PATIENT INFORMATION

Today's Date: ________________

(Mr. Mrs. Ms. Dr.) Last Name: ______________________ First Name: ________________________ M.I. _____ Sex: M /F

Address: ______________________________________________________________

City: __________________________________________ State: ____________________ Zip: ______________________

DOB: _________ Age: _____ SS# _____________________ DL# ______________ Email: ____________________

Home Phone: _______________________________ Cellular/Pager: _____________________________________________

Student / Employed Your Employer: ____________________________________ Work Phone: __________________

Who may we thank for referring you to our office? ________________________________ Phone#: _______________

Dentist: _________________ Phone #: ___________ Medical Dr.: _________________ Phone#: _____________

Pharmacy: _______________________________________________ Phone#: ___________________________________

Nearest relative not living with you: ____________________________ Phone #: ___________________________________

Married Single Divorced Separated Widowed Spouse's Name: ______________________________________

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Who will be responsible for your account: Self / Spouse / Father / Mother / Other: __________________________________
(If self, skip to next paragraph)

Name: ________________________________ SS#: ____________________ DOB: ______________________

Address: ______________________________________________________________ Home Phone: __________________

Employer: ______________________________________________ Phone#: ______________________

Address: ______________________________________________________________

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### PRIMARY INSURANCE INFORMATION

Insured Person: _______________________ Relationship to Patient: ___________ DOB: ________ SS# ______________

Address: ______________________________________________________________ Home Phone: __________________

Employer: _____________________________________ Phone#: ________________ Insurance: Medical / Dental

Ins Co. Name: ____________________________ Ins. Co. Address: ____________________________________________

Group #: _______________ Member ID #: ___________________________ Ins. Co. Phone #: _______________

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### SECONDARY INSURANCE INFORMATION

Insured Person: _______________________ Relationship to Patient: ___________ DOB: ________ SS# ______________

Address: ______________________________________________________________ Home Phone: __________________

Employer: _____________________________________ Phone#: ________________ Insurance: Medical / Dental

Ins Co. Name: ____________________________ Ins. Co. Address: ____________________________________________

Group #: _______________ Member ID #: ___________________________ Ins. Co. Phone #: _______________

******PLEASE ATTACH INSURANCE CARDS AND DRIVERS' LICENSE ******

**Emergency Contact:** __________________________ **Phone #:** _____________ **Relationship to Patient:** _____________