

# Maxillofacial and Facial Aesthetic Surgery, Ltd.

Kevin R. Haddle MD

## Registration Form

### PATIENT INFORMATION

Today's Date: \_\_\_\_\_  
Legal First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Number/ Street City State Zip Code  
Home Telephone: ( ) \_\_\_\_\_ Cellular Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_  
Home E-Mail Address: \_\_\_\_\_ Driver's License Number: \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: Male/Female Marital Status: Married/Single/Divorced/Widowed  
Nearest Relative: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_  
Employer: \_\_\_\_\_ Position: \_\_\_\_\_ Social Security #: \_\_\_\_\_

### GUARANTOR INFORMATION Same as Above

Legal First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last/Other Name(s): \_\_\_\_\_  
If Divorced or Separated, Other Parents' Full Name: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Address: \_\_\_\_\_  
Number/ Street City State Zip Code  
Home Telephone: ( ) \_\_\_\_\_ Cellular Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_  
Home E-Mail Address: \_\_\_\_\_ Driver's License Number: \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: Male/Female Marital Status: Married/Single/Divorced  
Employer: \_\_\_\_\_ Position: \_\_\_\_\_ Social Security #: \_\_\_\_\_

### VISIT INFORMATION

Visit is due to: \_\_\_\_\_  
If due to Injury, When, How, and Place? \_\_\_\_\_  
Treatment Requested: \_\_\_\_\_  
Previous Treatment or Surgery Performed by Whom? \_\_\_\_\_  
Where there Complications? \_\_\_\_\_  
Are you under the care of a psychiatrist? Who? \_\_\_\_\_  
Who is your Referring Dentist? \_\_\_\_\_  
Who is your Primary Care Physician? \_\_\_\_\_  
Who Referred you to this Office? \_\_\_\_\_

### INSURANCE INFORMATION

#### DENTAL INSURANCE

Insurance Company Name: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
Address: \_\_\_\_\_  
Number/ Street City State Zip Code  
Policy Number: \_\_\_\_\_ Subscriber Number: \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_ Subscriber DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ Employer: \_\_\_\_\_

#### MEDICAL INSURANCE

Insurance Company Name: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
Address: \_\_\_\_\_  
Number/ Street City State Zip Code  
Policy Number: \_\_\_\_\_ Subscriber Number: \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_ Subscriber DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ Employer: \_\_\_\_\_