Charleston Office
2270 Ashley Crossing Dr Ste 130
Charleston, SC 29414
(843) 410-5766

ORAL & IMPLANT
SURGERY OF THE LOWCOUNTRY

Charleston Office
506 Bells Hwy
Walterboro, SC 29488
(843) 782-6725

Patient Information Form

Referred By/How you heard about us: _____ General Dentist: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Preferred Name: _____ ◯Male ◯Female DOB: _____ SS#_____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: Home_____ Work_____ Cell_____

If you would like text message reminders, please provide your mobile provider: _____

Email address(s): _____

Employer/School (if student): _____

(Circle one) Marital Status: ◯Single ◯Married ◯Divorced ◯Widowed

Spouse Name: _____ Phone Number: _____

Physician: _____ Physician Number: _____

Pharmacy: _____ Pharmacy Number: _____

Emergency Contact/Relationship: _____ Number: _____

Name of family/friends treated in our office? _____

Legal Guardian/Guarantor/Subscriber Information (only for patients under 18 years of age)

Last Name: _____ First Name: _____ Middle Initial: _____

Marital Status: ◯Single ◯Married ◯Divorced ◯Widowed ◯Male◯Female DOB: _____ SS#: _____

Relationship to patient: _____ Employer: _____

Address: _____City: _____

State: _____ Zip:_____ Phone: Home_____ Work_____ Cell_____

Insurance Information

Primary Dental
Insurance Company: _____
Subscriber Name: _____
Subscriber DOB: _____
ID#: _____
Group#: _____

Secondary Dental
Insurance Company: _____
Subscriber Name: _____
Subscriber DOB: _____
ID#:_____
Group#:_____

Primary Medical
Insurance Company: _____
Subscriber Name: _____
Subscriber DOB: _____
ID#: _____

Secondary Medical
Insurance Company: _____
Subscriber Name: _____
Subscriber DOB: _____
ID#: _____

Patient's Signature: _____ Date: _____