Richmond Surgical Arts, Inc.

Gregory T. Lynam, M.D., D.D.S.

Chart# _____

(PLEASE PRINT AND FILL OUT THE FORM COMPLETELY)

Patient's Name: _____Sex: ____ M _____F
Patient's Address: _____Home Phone: _____
_____Cell Phone: _____

Soc. Sec.#: _____ Date of Birth: ____/ ____/ ____ Age: _____
Marital Status: _____Single _____Married _____ Divorced _____ Widowed

EMERGENCY CONTACT

Person to notify in case of emergency:_____Relationship: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____

EMPLOYMENT INFORMATION

Employer: _____Occupation: _____
Address: _____Work Phone: _____
Spouse's Name: _____Employer: _____
Address (if difference than above): _____Work Phone: _____

IF CHILD

Father's Name: _____ Employer: _____Work Phone: _____
Mother's Name: _____Employers: _____Work Phone: _____

INSURANCE INFORMATION

Do you have insurance coverage? _____Yes _____No

_____
Insurance Company

_____ ____/____/____
Subscriber Name Birthdate

_____
Subscriber Identification Number

_____
Group Number

Do you have secondary insurance? _____Yes _____No

_____
Insurance Company

_____ ____/____/____
Subscriber Name Birthdate

_____
Subscriber Identification Number

_____
Group Number

MEDICAL INFORMATION

Reason for Visit:_____ Is this due to an accident? _____
Date & Time of accident: ____/ ____/ ____ ____AM ____PM Date of First Treatment: ____/ ____/ ____
Is this a work-related injury? ____ Yes ____NO
Referring MD (First & Last Name) _____

I hereby authorize the above named physicians to release the information requested to the insurance company(ies) named herein. I hereby assign payment directly to the above named physicians of benefits otherwise payable to me. I understand that regardless of the Insurance coverage that I might have, I am financially responsible for all charges. I also agree that in the event that my account must be turned over to an attorney for collection that I will be responsible for attorney's fess, court cost and interest.

_____ _____
Signature Date