FALKE ORAL & FACIAL SURGERY

Dr. Ryan Falke

475 Sommersett Blvd Suite B
Reno, NV 89523
p: 775.284.2500

Today's Date _____

PATIENT INFORMATION:

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name _____ M.I. _____ Last Name _____

Sex: ❑ Male ❑ Female Birth Date _____ Age _____ Soc. Sec. # _____ E-mail _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Home Tel.(_____) _____ Cell.(_____) _____ Have you ever been a patient of our practice? ❑ Yes ❑ No

Referred By _____ (FIRST NAME) _____ (LAST NAME) Has a family member ever been a patient of our practice? ❑ Yes ❑ No

Dentist _____ (FIRST NAME) _____ (LAST NAME) Orthodontist _____ (FIRST NAME) _____ (LAST NAME) Medical Dr. _____ (FIRST NAME) _____ (LAST NAME)

Nearest relative not living with you _____ (FIRST NAME) _____ (LAST NAME) Tel.(_____) _____

Employer _____ Bus. Tel.(_____) _____ Ext. _____

In case of emergency, please contact _____ Tel. (_____) _____ Relation _____

SPOUSE OR OTHER GUARANTOR INFORMATION: *(IF DIFFERENT FROM ABOVE)*

Name _____ (FIRST NAME) _____ (LAST NAME) Relation _____ S.S.# _____ Birth Date _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Tel. (_____) _____ Employer _____ Bus. Tel.(_____) _____

INSURANCE INFORMATION:

Student: . . . . . ❑ Full Time ❑ Part Time ❑ Not . . . . . School Name and Address _____ (SCHOOL NAME) _____ (ADDRESS)

_____ (CITY) _____ (STATE) _____ (ZIP)

PRIMARY DENTAL INSURANCE COMPANY:

Insured Name _____ (FIRST NAME) _____ (LAST NAME)

Relationship _____ DOB _____ Sex: ❑ M ❑ F

Mailing Address _____

City _____ State _____ Zip _____

Social Security # _____

Home Tel. (_____) _____ Cell. (_____) _____

Custody / Court Order in Place? ❑ Yes ❑ No

Employer _____

Group Name _____

Insurance Company _____

ID # _____ ❑ PPO ❑ HMO

PRIMARY MEDICAL INSURANCE COMPANY:

Insured Name _____ (FIRST NAME) _____ (LAST NAME)

Relationship _____ DOB _____ Sex: ❑ M ❑ F

Mailing Address _____

City _____ State _____ Zip _____

Social Security # _____

Home Tel. (_____) _____ Cell. (_____) _____

Custody / Court Order in Place? ❑ Yes ❑ No

Employer _____

Group Name _____

Insurance Company _____

ID # _____ ❑ PPO ❑ HMO

SECONDARY DENTAL INSURANCE COMPANY:

Insured Name _____ (FIRST NAME) _____ (LAST NAME)

Relationship _____ DOB _____ Sex: ❑ M ❑ F

Mailing Address _____

City _____ State _____ Zip _____

Social Security # _____

Home Tel. (_____) _____ Cell. (_____) _____

Custody / Court Order in Place? ❑ Yes ❑ No

Employer _____

Group Name _____

Insurance Company _____

ID # _____ ❑ PPO ❑ HMO

SECONDARY MEDICAL INSURANCE COMPANY:

Insured Name _____ (FIRST NAME) _____ (LAST NAME)

Relationship _____ DOB _____ Sex: ❑ M ❑ F

Mailing Address _____

City _____ State _____ Zip _____

Social Security # _____

Home Tel. (_____) _____ Cell. (_____) _____

Custody / Court Order in Place? ❑ Yes ❑ No

Employer _____

Group Name _____

Insurance Company _____

ID # _____ ❑ PPO ❑ HMO