William C. Storoe IV D.D.S. P.A.

Oral & Maxillofacial Surgery

Board Certified
American Board of Oral & Maxillofacial Surgery

3500 S.W. 2nd Avenue, Suite 2
Gainesville, Florida 32607
(352) 371-4111 FAX (352) 371-1139

1779 SW Barnett Way
Lake City, Florida 32025
(386) 961-9199 FAX (386) 754-0092

Patient: (Mr. Mrs. Ms. Dr.) First Name ____________________ M.I. _____ Last Name ______________________ Nickname ____________________

Sex: ☐ Male ☐ Female Date of Birth ______________ Age ____ Soc. Sec.# ____________________Driver's Lic # ____________________

Street ____ City _______________________ State ______________ Zip ________________

Home Tel # (______) __________________ Business Tel. # (______)___________________ Ext. _______ Employer____________________

Cell Phone # (______) ________________________ Student: Full Time ☐ Part Time ☐ School: ___________________________________

Emergency Contact: ____ Phone Number: (______) ______________________________

Have you ever been a patient of our practice? ☐ Yes ☐ No Method of Personal Payment: ☐ Cash ☐ Check ☐ Credit Card

Dentist _____________________ Orthodontist ____________________ Physician _____________________ Referred By: _______________

Married ☐ Divorced ☐ Legally Separated ☐ Widow ☐ Single ☐

How did you hear about our office? ☐ Dentist ☐ Yellow Pages ☐ Our Web Site ☐ Former Patient ☐ Gainesville Medical Directory

☐ Magazine _____________________ ☐ Newspaper _____________________ ☐ Web Site __________________☐ Other _____________

Who will be responsible for your account? ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other ______________________________

Name _______________________ Soc. Sec. # __________________________ Date of Birth ______________ Home Tel. # _______________

Street ____ City _______________________ State ______________ Zip ________________

Employer ____ Tel. # (_____)_______________________

Please allow us to make a copy of your insurance cards.

DELTA DENTAL INSURANCE COMPANY (ONLY)	**PRIMARY MEDICAL INSURANCE COMPANY**
Employer __________________________	**Employer** __________________________
Bus. Address __________________________	Bus. Address __________________________
Bus. Tel. # (_____)_______________ Plan ____________	Bus. Tel. # (_____)_______________ Plan ____________
Ins. Co. Name __________________________	**Ins. Co. Name** __________________________
Address __________________________	Address __________________________
______________________Tel. # (_____)_____________	______________________Tel. # (_____)_____________
Group # ____________ **Group Name** ______________	**Group #** ____________ **Group Name** ______________
Insured Party ________________ Relation ______________	Insured Party ________________Relation ______________
Sex: ☐ M ☐ F Date of Birth __________________	Sex ☐ M ☐ F Date of Birth __________________
Street __________________________	Street __________________________
City, State, Zip __________________________	City, State, Zip __________________________
Tel. # (_____)________________ S.S. # ______________	Tel. # (_____)________________S.S. # ______________
I.D. # __________________________	I.D. # __________________________

(OVER)→