

**WALTER J. JUNG, D.D.S.**  
**Southern Louisiana Oral & Maxillofacial Surgery**  
**8680 BLUEBONNET BLVD., STE. C**  
**BATON ROUGE, LA 70810**  
**(225) 767-7212**

**TODAY'S DATE:** \_\_\_\_\_ **DID YOU BRING X-RAYS? YES NO SENT OVER**

**REASON FOR TODAY'S VISIT: (CK One) Extractions \_\_\_ Wisdom Teeth \_\_\_ TMJ \_\_\_ Fracture \_\_\_ Other \_\_\_**

**PATIENT INFORMATION:**

Patient's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Male / Female Age: \_\_\_\_\_

Marital Status:      Single              Married              Divorced              Child / Minor              Widowed

Patient's Address: \_\_\_\_\_  
\_\_\_\_\_ Zip: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Home Telephone Number: \_\_\_\_\_ Work Number: \_\_\_\_\_ Cell Number: \_\_\_\_\_

Patient's Employer's Name and Address: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Referring/General Dentist: \_\_\_\_\_

Spouse/Parent/Guardian's Name: \_\_\_\_\_

Spouse/Parent/Guardian's Employer: \_\_\_\_\_ Work Number: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

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**PRIMARY CARD HOLDER INFORMATION (Even if it is the same as above you must fill out this portion)**

**\*WE MUST HAVE THIS INFORMATION AND INSURANCE CARDS TO VERIFY INSURANCE BENEFITS. YOU MAY WRITE PRIVATE PAY IF YOU DO NOT HAVE INSURANCE.**

Medical Insurance Companies Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Dental Insurance Companies Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Insured Last Name: \_\_\_\_\_ First Name \_\_\_\_\_ MI: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
(This is the name of the card holder, i.e. Self, Spouse, Parent)

Insured Date of Birth: \_\_\_\_\_ Insured Social Security #: \_\_\_\_\_

Insured Address: \_\_\_\_\_ Zip: \_\_\_\_\_

Insured Employer's Name: \_\_\_\_\_

Home Telephone Number: \_\_\_\_\_ Work Telephone Number: \_\_\_\_\_

Patient Signature/Parent (if minor): \_\_\_\_\_ Date: \_\_\_\_\_

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