Welcome

PATIENT INFORMATION

TODAY'S DATE: _____
First name: _____ Middle name: _____ Last name: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Home phone: _____ Work phone: _____ Cell Phone: _____
Age: _____ Birthday: _____ Social Security number: _____
Email address: _____
Whom may we thank for referring you? _____
If responsible party is different from patient, please provide the following information:
Name:
Street address:
City: _____ State: _____ Zip code: _____
Home phone: _____ Work Phone: _____ Cell phone: _____
Relationship to you: _____

DENTAL INSURANCE INFORMATION

Policyholder's name: _____ Relationship to Patient: _____
Social security number: _____ Birthdate: _____
Dental insurance company name: _____ Group number: _____
Name of employer: _____ Employer's phone number: _____
Do you have dual dental insurance coverage? YES ☐ NO ☐
If yes, please provide the following information for your secondary insurance coverage:
Policyholder's name: _____ Relationship to Patient: _____
Social Security Number: _____ Birthdate: _____
Dental insurance company name: _____Group Number: _____
Name of employer: _____ Employer's phone number:_____
Have you provided a copy of your insurance card(s) to our office? YES ☐ NO ☐

EMERGENCY INFORMATION

Name of emergency contact: _____ Relationship to you: _____
Street address: _____
City: _____ State: _____ Zip Code: _____
Home phone: _____ Work phone: _____ Cell Phone: _____

AUTHORIATION

I have read and answered the above questions to the best of my knowledge. I certify that I have insurance coverage as stated above, and I authorize my insurance company to assign benefits directly to Dr. Davis, D.D.S., P.C. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges whether or not they are paid by insurance.

Signature of Responsible Party: _____ Date: _____