Welcome

1 About You

Patient Name:_____
Last First Middle

Prefer to be called:_____ ☐ Male ☐ Female
Birthdate: ____/____/____ Age:_____ SS#:_____
Driver's License#:_____ Birthplace:_____
Home Address:_____
_____
City State Zip
Home Phone:_____ Work Phone:_____
Cell Phone:_____ Pager:_____
E-Mail Address:_____
Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Employer:_____Length of Employment:_____
Employer's Address:_____
_____
City State Zip
Occupation:_____
Spouse's Name:_____
Last First Middle
Work Phone:_____ Cell Phone:_____

2 Insurance Information

Primary Dental Insurance
Insurance Co. Name:_____
Address:_____
_____
City State Zip
Phone#:_____
Insured's SS#:_____
Group, Plan or Policy #:_____
Insured's Name:_____
Relation:_____ Date of Birth___/___/___
Insured's Employer:_____

Secondary Dental Insurance
Insurance Co. Name:_____
Address:_____
_____
City State Zip
Phone#:_____
Insured's SS#:_____
Group, Plan or Policy #:_____
Insured's Name:_____
Relation:_____ Date of Birth___/___/___
Insured's Employer:_____

3 Account Information

Person Responsible for Account
Name:_____
Last First Middle
Relation:_____
Billing Address:_____
_____
City State Zip
SS#:_____ Driver License#:_____
Home Phone:_____ Work Phone:_____
Payment Method: ☐ Cash ☐ Check ☐ Credit Card

4 In Event of Emergency

Who should we contact?_____
Relation:_____
Home Phone:_____
Work Phone:_____
Cell Phone:_____
Who is your Medical Doctor?_____
Doctor's Phone:_____

THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I/We give the above information for the purpose of obtaining credit and authorize you to obtain further information concerning any statement made from any source. I/We agree that all credit will be governed by the Financial Agreement and initial Disclosure Statement and if more than one signature appears below, will be our joint and several obligations. I/We understand that a service charge will be charged on balances older than sixty (60) days at the rate of 1.75% per month or at a minimum of $2.50 on the unpaid balance. I hereby authorize insurance payment to F.A. Davis, Jr., D.D.S., P.L.L.C. dba Davis Dental Clinic.
Patient Signature:_____ Dated:_____