DAVIS DENTAL GROUP

113 132nd Street South • Tacoma, Washington 98444 • (253) 537-9317

This completely confidential information is important for our records and required for professional dental services to be provided.

PATIENT INFORMATION:

Name _____ Birthdate _____
FIRST MIDDLE LAST

Nickname _____ Email _____ SS# _____

Address _____ City-State-Zip _____

Telephones: Home _____ Work _____ Cell _____

Employer/School _____ Occupation _____

Names of other family members in our practice _____

Whom may we thank for referring you to our office? _____

Emergency Contact _____ Phone _____

FINANCIAL INFORMATION: Person financially responsible for account:

Name _____ Birthdate _____ Relationship to Patient _____

Address _____ City-State-Zip _____

Telephones: Home _____ Work _____ Message _____

SS# _____ Employer _____ Occupation _____

Name of your Bank _____ Preferred method of payment? ☐ Cash ☐ Credit ☐ Debit

Do you rent or own your home? _____ How long? _____

ARE OTHER ADULT FAMILY MEMBERS EMPLOYED?: ☐ YES ☐ NO

Name _____ Birthdate _____ Relationship to Patient _____

Address _____ City-State-Zip _____

Telephones: Home _____ Work _____ Message _____

SS# _____ Employer _____ Occupation _____

DENTAL INSURANCE INFORMATION:

Employee Name _____ DOB _____ SS# _____

Name of Ins. Co. _____ Ins. Phone# _____ Group-Local # _____

Address of Ins. Co. _____

ADDITIONAL DENTAL COVERAGE:

Employee Name _____ DOB _____ SS# _____

Name of Ins. Co. _____ Group-Local # _____

Address of Ins. Co. _____

I understand that professional services are rendered directly to the patient and therefore I am directly responsible to Davis Dental Group for the obligation of payment for treatment.

I authorize Davis Dental Group to release information relating to my dental care to my insurance company and authorize any insurance payment to be made directly to Davis Dental Group.

Signature _____ **Date** _____