Nile M. Davis, D.D.S., P.C. - Orthodontics

Date ____________

Patient Information:

Patient's Name ______________________________
Last First Middle Nick-Name

Address ______________________________
Street City State Zip

Home Phone ____________ Cell Phone ____________ Birthdate ________ Age ____ Sex ____

Patient's E-Mail ____________ Are you on FaceBook ? No ☐ Yes ☐ Twitter ? No ☐ Yes ☐

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

If patient is a minor, give parent or guardian's name ______________________________

Responsible Party Information:

Name ______________________________ ____________
Last First Middle Marital Status

Residence ______________________________
Street City State Zip

Mailing Address ______________________________
Street City State Zip

How long at this address ____________ Home Phone ____________ Work Phone ____________

Previous Address (if less than 3 yrs.) ______________________________
Street City State Zip

Social Security # ____________ Birthdate ____________ Relationship to Patient ____________

Employer ____________ Occupation ____________ No. Years Employed ____________

Spouse's Name ______________________________ Relationship to Patient ____________
Last First Middle

Employer ____________ Occupation ____________ No. Years Employed ____________

Social Security # ____________ Birthdate ____________ Work Phone ____________

Dental Insurance Information: None ☐

Policy Holder's Name ______________________________ Social Security # ____________

Insurance Company ____________ Group No. ____________ Union Local No. ____________

Insurance Co. Address ______________________________ Insurance Co. Phone ____________

Policy Holder's Employer ______________________________

Do you have dual coverage? No ☐ Yes ☐

Policy Holder's Name ______________________________ Social Security # ____________

Insurance Company ____________ Group No. ____________ Union Local No. ____________

Insurance Co. Address ______________________________ Insurance Co. Phone ____________

Policy Holder's Employer ______________________________

Emergency Contact Information:

Name of nearest relative not living with you ______________________________

Complete Address ______________________________

Home Phone ____________ Cell Phone ____________ Relationship ____________

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) ______________________________

Update (Initial & Date) ____________ Update (Initial & Date) ____________

A B C

06/10