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Patient Information

Name _____
 First M/I Last Nickname

Age _____ Birth Date _____ / _____ / _____ Sex _____ Email _____
 Month Day Year

Address _____

City _____ Zip Code _____ Phone _____

RESPONSIBLE PARTY INFORMATION

FATHER/GUARDIAN or SELF (if Adult Patient) INFO

Name _____
 First M/I Last

Mailing Address _____

City _____ State _____ Zip _____

Physical Address _____

Previous Address _____

How long at current address? _____ How long at previous address? _____

Phone _____ Work _____ Cell _____

Email _____ Age _____

Birthday _____ Relationship to Patient _____

Driver's License # _____ S.S. # _____

Marital Status: Single Married Separated Divorced Widowed

EMPLOYER INFORMATION

Employer Name _____

Employer Address _____

City _____ State _____ Zip _____

Occupation _____ No. of Years Employed _____

Orthodontic Coverage? Yes _____ No _____

Insurance Company Name _____

Insurance Address _____

Insurance Phone _____ Ext. _____

Group No. _____ Plan No. _____

Insurance I.D. _____ Secondary/Dual Ins.? Y N

MOTHER/SPOUSE INFORMATION

Name _____
 First M/I Last

Mailing Address _____

City _____ State _____ Zip _____

Physical Address _____

Previous Address _____

How long at current address? _____ How long at previous address? _____

Phone _____ Work _____ Cell _____

Email _____ Age _____

Birthday _____ Relationship to Patient _____

Driver's License # _____ S.S. # _____

Marital Status: Single Married Separated Divorced Widowed

EMPLOYER INFORMATION

Employer Name _____

Employer Address _____

City _____ State _____ Zip _____

Occupation _____ No. of Years Employed _____

Orthodontic Coverage? Yes _____ No _____

Insurance Company Name _____

Insurance Address _____

Insurance Phone _____ Ext. _____

Group No. _____ Plan No. _____

Insurance I.D. _____ Secondary/Dual Ins.? Y N

OTHER INFORMATION

Person Responsible for Account _____

Other Children/Siblings _____ Age _____
 _____ Age _____
 _____ Age _____
 _____ Age _____

Emergency Contact Name _____ Relationship to Patient _____

Complete Address _____ Phone _____

Dentist Name _____

School Name _____ Grade _____

Do you play a musical instrument? YES NO

Sports or Hobbies _____

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

