



Joanna L. Davis D.D.S., M.S. and Brett M. Strong, D.D.S.

PATIENT INFORMATION

Patient Name: _____ SS Number: _____
Address: _____ Home Telephone: _____
City: _____ State: _____ Zip: _____ Cell Telephone: _____
Age: _____ Date of Birth: _____ Driver's Lic #: _____ Married Single
Employer: _____
Work Address: _____ Work Telephone: _____
General Dentist: _____ Referred By (if different): _____

FINANCIALLY RESPONSIBLE PERSON *(if different from patient)*

Responsible Person: _____ Relationship: _____
Address: _____ Home Telephone: _____
City: _____ State: _____ Zip: _____ Cell Telephone: _____
Age: _____ Date of Birth: _____ DL#: _____ SS No _____ Married Single
Employer: _____
Work Address: _____ Work Telephone: _____

PRIMARY DENTAL INSURANCE INFORMATION

Name of Insured: _____ Date of Birth: _____ SSN: _____
Insurance Company: _____
Claims Mailing Address: _____
City: _____ State: _____ Zip: _____
Employer: _____
Policy Number: _____ Group Number: _____

-I understand that I am responsible for payment of all treatment received and that my insurance will be filed as a courtesy to me.

-I authorize the release of any information including the diagnosis and the records of any examination and/or treatments rendered, to any other health care providers, such as my dentist or physician, who may be involved in my case.

Signed: _____ **Date:** _____