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Doctors
Davis & Beyer
Dental Health Professionals
"Excellence by Choice"

www.venicedentist.com
Email: info@venicedentist.com

PATIENT INFORMATION

Date: _____

Name: _____ I prefer to be called: _____

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: _____ Work: _____ Cell: _____

Out of town Address: _____ City: _____ State: _____ ZIP: _____

Email Address: _____

Date of Birth: _____ Age: _____ Social Security Number: _____

Place of Birth: _____

Sex: M ❒ F ❒ Marital Status: Married ❒ Single ❒ Widowed ❒ Divorced ❒ Student ❒

Place of Employment: _____ Occupation: _____

Spouse or Parent's Name: _____ Employer: _____ Phone: _____

Has any member of your family ever been treated in our office? Yes ❒ No ❒

Whom may we thank for referring you? _____

PERSON TO CONTACT OUTSIDE OF IMMEDIATE FAMILY IN CASE OF EMERGENCY

Name: _____ Tel #: _____

Address: _____ City: _____ St ____

DENTAL INSURANCE INFORMATION

Insured's Name: _____

Insurance Co: _____

ID/SNN Number: _____

Group #: _____

SECONDARY DENTAL INSURANCE INFORMATION

Insured's Name: _____

Insurance Co: _____

ID/SNN Number: _____

Group #: _____

METHOD OF PAYMENT: I prefer to pay by: Check ❒ Cash ❒ Credit Card ❒

FINANCE CHARGE: *If I do not pay the entire New Balance within 25 days of the statement date a FINANCE CHARGE will be added to the account for the billing period. The FINANCE CHARGE will be periodic rate of 1% per month which is an ANNUAL PERCENTAGE RATE OF 12%. In case of default of payment I promise to pay any legal interest on the balance due, together with Any collection costs and reasonable attorney fees incurred to effect collection of this account.*

APPOINTMENTS: *Please be advised 24 hours notice must be given if a cancellation is absolutely necessary, otherwise you will be charged a cancellation fee.*

AUTHORIZATION: *I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer medications, perform diagnostic and therapeutic procedures as may be necessary for proper dental care. I certify that the above information & medical history is true and correct to the best of my knowledge.*

Patient Signature: _____

Please Continue Filling Out Your Information On The Other Side Of This Form