Welcome to New Smyrna Cosmetic & Family Dentistry

Dr. James R. Davis, DDS

Please supply the following information in order that we may better serve you.

Name (First, Middle Initial, Last)	Preferred Name	Date	Sex
	( )	/ /	☐ M ☐ F

Address	City	State	Zip	Date of Birth	Age
				/ /	

Home Phone	Work Phone	Cell Phone	Social Security Number
( )	( )	( )	- -

Email Address

Occupation	Employer

Work Address	City	State	Zip

☐ *This patient is a child and I, _____, am the parent or legal guardian and by signing am authorizing treatment.*

Whom shall we contact in the event of an emergency?

Name: Phone ( )

Who is responsible for the payment of this account?

_____Self _____Spouse _____Parent _____Other

Patient Status: _____Single _____Married _____Divorced _____Separated _____Widowed _____Child

Spouse or Parent Name: Date of Birth:

Social Security Number: Employer:

Do you have dental insurance? _____Yes _____No

If yes, please present card at front desk, and complete the following…

Insurance Company_____ Insurance Phone_____

Insurance Phone_____ SSN_____

Contract #_____ Group #_____ Subscriber #_____