



DAVENPORT & ROHRABAUGH, INC.

Anchored in Caring....

Patient Information

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Name _____ Date _____

First MI Last

Address _____ City _____ State _____ Zip _____

Birthdate _____ Home phone # _____ Work phone # _____

Cell phone # _____ Email Address _____

Are You: Minor Married Divorced Widowed Single Separated

If you are a student, name of school/college _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency _____ phone # _____

Responsible Party

Name _____ SS# _____ Birthdate _____

Relationship to patient _____ Home # _____ Cell # _____

Address _____ City _____ State _____ Zip _____

How long at this address _____ Previous address (if less than 3 yrs.) _____

Name of employer _____ Work # _____ # yrs. Employed _____

Spouse's Information

Name _____ SS# _____ Birthdate _____

Name of employer _____ Work# _____ # yrs. Employed _____

Insurance Information

Name of insured _____ SS# _____ Birthdate _____

Employer _____ Insurance Company _____ Group # _____

Do you have additional insurance? No Yes If yes, please complete the following:

Name of insured _____ SS# _____ Birthdate _____

Employer _____ Insurance Company _____ Group # _____