James L. Davenport II, DDS

Patient Information

Thank you for choosing our practice for you 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 you.

Name _____ Birth _____ Social Security # _____

Address _____

City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____ Work Phone _____

Email _____

Your (or parent's) Employer _____

Spouse/Parents' Name _____ Phone _____

Whom may we thank for referring you to us? _____

Person to contact in case of an emergency _____ Phone _____

Responsible Party

Name of the person responsible for this account? _____

Relationship to patient _____ Phone _____

Address _____

City _____ State _____ Zip _____

Social Security # _____ Birth Date _____

Responsible Party's Employer _____ Phone _____

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birth Date _____ Social Security # _____ Ins. Co. _____

Group # _____ Patient's ID # _____

Do You Have Additional Insurance? _____. Ins Co. _____. Name of Insured _____

Date of Birth _____ Social Security # _____ Group # _____

Please Check Any of the following conditions that apply to you:

_____ Bad breath
_____ Bleeding gums
_____ Clicking or popping jaw
_____ Food collection between teeth
_____ Grinding teeth
_____ Like Better Smile
_____ Like straighter teeth
_____ Like whiter teeth
_____ Loose teeth or broken filling
_____ Sensitivity to hot/cold
_____ Sensitivity to sweet
_____ Sensitivity when biting
_____ Sores/growths in mouth
_____ TMJ Disorder