David P. Ney DDS, PA

RESTORATIVE & COSMETIC DENTISTRY

Patient Information

Date _____

Name _____
First Middle Initial Last

Home Phone _____ Work Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Social Security #: _____ E-mail _____ DOB: _____

Check Appropriate Box ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Patient's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

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

Who May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Social Security #: _____ Birthdate _____

Employer _____ Work Phone _____

Occupation _____

Is This Person Currently a Patient in our Office? ❑ Yes ❑ No

Dental Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security #: _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Phone _____

Ins. Co. Address _____ City _____ State _____ Zip _____

I authorize my insurance company to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Insurance Authorization Signature _____ Date _____

4938 HWY 49 SOUTH · HARRISBURG, NC 28075 · PHONE: 704.454.7711 · FAX: 704.454.7722