VILLAGE PLAZA DENTAL

4750 Village Plaza Loop #201 • Eugene, OR 97401

343-3822

PATIENT INFORMATION

DATE _____

PATIENT INFORMATION

☐ MR. ☐ MRS. ☐ MISS | LAST NAME | FIRST | MIDDLE | AGE | DATE OF BIRTH / / | M | F | SOCIAL SECURITY # – –

PERSON LEGALLY RESPONSIBLE

☐ MR. ☐ MRS. ☐ MISS | LAST NAME | FIRST | MIDDLE | DATE OF BIRTH

MAILING ADDRESS | CITY | STATE | ZIP | HOME PHONE

EMPLOYED BY | OCCUPATION | SOCIAL SECURITY NUMBER

BUSINESS ADDRESS | CITY | STATE | ZIP

BUSINESS PHONE – EXT. | PAGER/CELL # | E-MAIL ADDRESS

SPOUSE/PARTNER INFORMATION

NAME OF SPOUSE (LAST) | FIRST | MIDDLE | DATE OF BIRTH

SPOUSE EMPLOYED BY | OCCUPATION | SOCIAL SECURITY NUMBER

BUSINESS ADDRESS | CITY | STATE | ZIP

BUSINESS PHONE – EXT | PAGER/CELL # | E-MAIL ADDRESS

Name of nearest relative not living with you _____ Relationship to patient _____

Address _____ City _____ Zip _____ Phone (____) _____

Whom may we thank for referring you? _____

Do you have dental insurance? ☐ Yes ☐ No

Primary Insurance Co. name & address

_____

_____

_____

Phone No.: _____

Policy Holder: _____

Policy Holder Address: _____

_____

Birth Date: _____

SS # or ID #: _____

Group #: _____

Employer: _____

Address: _____

Is there double coverage? ☐ Yes ☐ No

Secondary Insurance Co. name & address

_____

_____

_____

Phone No.: _____

Policy Holder: _____

Policy Holder Address: _____

_____

Birth Date: _____

SS # or ID #: _____

Group #: _____

Employer: _____

Address: _____

I hereby authorize payment directly to Damion D. Gilday, D.M.D., P.C. Insurance Benefits _____

I, the undersigned (patient or legally responsible party), authorize dental treatment to be rendered by the Dentist and his Staff. I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance. If it becomes necessary to effect collections of any amount owed on this or subsequent visits the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure the payment of benefits.

Signature: _____ Date: _____