



John J. Denison, D.D.S., P.C.

Family & Cosmetic Dentistry
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The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely. The better we communicate, the better we can care for you. Thank you.

First Name _____ Last Name _____

Middle In _____ Nick Name _____ Salutation _____

Check all that apply: Patient Policy Holder Responsible Pary

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Employer _____ Phone _____ Ext _____

Sex: Male Female Status: Married Single Minor (under 18 years old)

Birthdate ____ / ____ / ____ Social Security # _____ Driver License # _____

Email _____ Can we email you? Yes No Can we text you? Yes No

Who may we thank for referring you? _____

Person to notify in the case of an emergency _____

Relationship _____ Work# _____ Home# _____

Responsible Party _____ Home Phone _____

Address _____ Work Phone _____

City _____ State _____ Zip _____ Employer _____

Birthdate ____ / ____ / 19 ____ Social Security # _____

If you have given us a Post Office Box for your mailing address, please provide your actual physical address:

Street _____ City _____ State _____

-over please-

Insurance Information and Authorization

Primary Insurance Coverage:

Name of Insured _____

Relationship to Patient _____

Insured's Birth date _____ / _____ / 19____ Social Security # _____

Employer/School _____ Phone _____

Name of Insurance Company _____ Phone _____

Group#/Name _____ Id# _____

Deductible Amount _____ Max Annual Benefit _____

Secondary Insurance Coverage:

Name of Insured _____

Relationship to Patient _____

Insured's Birthdate _____ / _____ / 19____ Social Security# _____

Employer/School _____ Phone _____

Name of Insurance Company _____ Phone _____

Group#/Name _____ Id# _____

Deductible Amount _____ Max Annual Benefit _____

Please Read and Sign:

The payment for services is due on the day services are rendered, unless other means of payment are agreed upon by the undersigned and the office of John J Denison, D.D.S., P.C. I authorize the filing of claims against any insurance in force, and further assign and direct payment to John J Denison, D.D.S., P.C. The undersigned understand that he/she is responsible for payment of any charges not covered by this assignment, and that any monies recovered in excess of the patient's indebtedness will be refunded. In the event of default on any payment due I agree to pay all costs of collection as well as any attorney fees and court costs deemed reasonable by the court. I authorize my dental treatment and release of any medical or dental information to process claims for services rendered.

Signature _____ Date _____

Signature of patient over 18 years of age or parent or legal guardian