DAVID K. NANCE, DDS
285 East 400 South, Springville, UT 84663
Phone: (801) 489-1000

PATIENT INFORMATION (ADULT)

Patient Name: ______________________________

Address: ______________________ P.O. Box: ______________

City: ______________ State: __________ Zip: ______________

☐ Male ☐ Female Age: ________ Nickname: ______________

Home Phone: __________ Cell Phone: __________ Email: ______________

Would you like to have your appointment reminders by email or text message? ______________

Birth Date: __________ Social Security# ______________ Marital Status: ☐ M; ☐ S: ☐ W; ☐ D

Patient's Occupation: ______________________ No. Of Dependents ______________

Full Time Student: __________ If yes, Name of School: ______________

Spouse's Name: ______________ Spouse's SS#: __________ Occupation ______________

Spouse's Employer: ______________________ Business#: ______________

In case of emergency, please notify my nearest relative or acquaintance not living with me.

Name: ______________________________

Address: ______________________________

Phone: ______________ Relationship: ______________

Person Responsible for Payment of this Account

Name of Responsible Party: ______________ Relationship: ______________

Address: ______________________ P.O. Box: ______________

City: ______________ State: __________ Zip: __________ AGE: __________

Home Phone: __________ Cell Phone: __________ Email: ______________

Birth Date: __________ Social Security# __________ Driver's Lic.# ______________

Employer: ______________________ Employer Phone # : ______________

Employer Address: ______________ City: __________ State: ______ Zip: ______________

Will dental insurance be involved: ______________________ If yes, please complete next section.

Patient Insurance information (Use your ID card)

Subscriber's Name: ______________ Subscriber's Address: ______________

Subscriber's #: ______________ Subscriber's Birthdate: ______________

Subscriber's SS#: ______________ Relationship to Insured: ______________

Name of Insurance Company: ______________ Group#: __________ ID#: __________

Address to send claims: ______________________________

Subscriber's Employer: ______________ Employer Phone # : ______________

Effective Date: ______________ Do you carry secondary insurance: ______ If yes, complete next section.

Secondary Insurance information (Use your ID card)

Subscriber's Name: ______________ Subscriber's Address: ______________

Subscriber's #: ______________ Subscriber's Birthdate: ______________

Subscriber's SS#: ______________ Relationship to Insured: ______________

Name of Insurance Company: ______________ Group#: __________ ID#: __________

Address to send claims: ______________________________

Subscriber's Employer: ______________ Employer Phone # : ______________

Effective Date: ______________