Joshua Nellis, DDS
THE WOODLANDS DENTIST

PATIENT INFORMATION

Name _____ Date _____
First Mi Last

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

E-mail _____ Cell Phone _____ Home Phone _____

SS#/SIN _____ Birthdate _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If College Student, F.T./P.T., Name of School _____ City _____ State/Prov. _____

Patient's or Parent's/Guardians Employer _____ Work Phone _____

Business Address _____ City _____ State/Prov. _____ Zip/P.C. _____

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

Whom May We Thank for Referring You? _____

Person to Contact in Case of an Emergency _____ Phone _____

Responsible Party

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

Address _____ Home Phone _____

Driver's License No. _____ Birthdate _____ SS#/SIN _____

Employer _____ Work Phone _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Employer Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Co. _____ Tel. # _____ Grp # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How Much is Your Deductible? _____ How Much Have You Used? _____ Max Annual Benefit? _____

Do You have any Additional Insurance? ☐ Yes ☐ No If Yes, Complete the Following: _____

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name Of Employer _____ Union or Local # _____ Work Phone _____

Employer Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Co. _____ Tel. # _____ Grp # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How Much is Your Deductible? _____ How Much Have You Used? _____ Max Annual Benefit? _____

Signature of Patient/Parent/Guardian _____ Patient Number _____